_		1 - For State Registrar 1. Decedent's Name (First, Middle, I		-	ertificate of De		Reg. No	ZUUb	2400
Physic		1. Decoderit's Name (First, Whole, I		James Gos	nell	Mor	nth Da	y Yeer 4, 2006	6:18 a.m. ^M
/Medi Examir		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or Lo	cation of Death		County of Death	
			6737 Pine D			Columbi			oward
Funeral Director		5. Social Security Number 6. 215.18.7989 Usual Residence of Decedent	Sex 7. Ag	ge (In yrs. last birthday, 83 Yrs.			of Birth oth, Day, Year) lay 4, 192		place (State or Foreign htry) Maryland
yland yland		10a. State 10b. County		10c. City, Town or L	ocation			1	Od. Inside City Limits
Mar a-fet	ctor	Maryland	Howard		Co	lumbia			1 ☐ Yes 2 🔀 No
h with the 23a or 28	al Director	10e. Street and Number 6737 Pine Drive			10f, Zip Code	21046	10g. Ci	tizen of What Coul U.S	*
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modral Explainer must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces: 1	No 1942 1945		anic Origin? (Specify Yes Mexican, Puerto Rican, e Specify:	s or No-	14. Race - Americ Black, White, Specify:	
72 ho	Completed	15. Decedent's (Specify only highest of	Education grade completed)	(Give	edent's Usual Occupations kind of work done during	n ng most of working	16b. K	(ind of Business/In	dustry
within ne.	mp	Elementary/Secondary (0-12)	College (1-4or	life	DO NOT use retired)	onal officer		correctio	nal facility
be filed v ntal Hygie ed other t	ပ္ပ	17. Father's Name (First, Middle, La	st)			I. Mother's Name (First,	Middle Maider	Sumame)	
d 2 should be filed within 72 hours aft th and Mental Hygiene. 71 is marked other than "natural", or traumatic event, 11s M. circal Expent	To Be		es W. Gosnell			, , , , , , , , , , , , , , , , , , , ,		illian Gill	
s 1 and 2 should E f Health and Ment item 27 Is marked other traumatic	-	19a. Informant's Name/Relationship		19b. Mail	ing Address (Street and	Number or Rural Route	Number, City	or Town, State, Zip	Code)
C = C4 F		Ms. Ellen C. Gosn	ell Spor	use	6737 Pine Drive	Columbia, Mary	land 2104	6	
00		20a. Method of Disposition 1 ☐ Purial 2 ☐ Cremation 3	☐Removal from State	20b. Place of Disp cemetery, cre	osition (Name of omatory or other place)	Date	20c. L	ocation - City or To	own, State
permit. Pages Department of Important: If it any injury or o		4 □Donation 5 □ Other (Spe	city)	Good	Shepherd Ceme	4)	006	Ellicott City	, Maryland
Depar Mpor mpor any in		21. Staffature of Fune al Service Lic	ense	125 35 - 2	2. Name and Address of Slack Fu	of Facility Ineral Home, P.A			
401 8 G		3a Part 1. Enter the disease or co	mulications that cause		3871_Old	d Columbia Pike	Ellicott Cit	y, MD 21043	Approximate
Physician /Medical		23a Part1. Enter the disease, or co shock, or heart failure. List on Inmediate Cause (Final disease or condition resulting in death)	_ a	a consequence of):	Α. /) vene			Onset and Death
Examiner		Sequentially list conditions	b						
P #	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
and and II-tran	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequence of):					
tificate be executed g physician and as the burial-transit	edical E		d						
		IF FEMALE:	00-14						
Attending Physician: The law requires that the death certific death. cder. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetel death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ery Day Year
s that ned b	y Pt	Part II. Other significant conditions	contributing to death t	out not resulting in the	underlying cause given i	n Part I. 236	Did tobacco	use contribute to the	ne cause of death?
w require been sig should b		Cardio	myo pathy				1 Yes 2	□No 3□Prob	pably 4 Unknown
law re las bee	Completed		()			248	. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
hysician: The law his certificate has b I director, page 2 s	Son					10	yes 2 No	death? 1 ☐ Yes	
ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:		Cthor	6. Place of Death (Check	1		
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or Attending Physician: The law requires that the death cerater dearth cerater dearth; second to the strending the funeral director, page 2 should be detached for use	ıtlon	1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	Year) Injury	Work?	2 □ No	Sonso nov inju	19 00001100	
of or Atter s after dea ll Director d in by the	Certification:	3 Suicide 6 Could not determine	286. Place of in	jury - At home, farm, st tc. (Specify)	treet, factory, office	28f. Loc. City	ation (Street ar or Town, State	nd Number or Rura a)	I Route Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physicien: To the best eminer: On the basis of and manner st	of examination and/or in	th occurred at the time, nvestigation, in my opinion	date and place, and due on, death occurred at the	to the cause(se time, date and) and manner as s d place, and due to	tated. the cause(s)
To # To #	W	29b. Signature and little of certifier	Nelle		29c. License nu	D34613	29d. Da	te signed (Month,	Day, Year)
6		30. Name and address of person who Geller, Steven A. MI	o completed cause of 8186 Lark Bro	death (Item 23a) (Type own Rd. Suite :	, Print) 201 Elkridge, M	D 21075		1	
7	ate rar	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature					
HMH 17 Rev 1/2		AUG 0 1	LUUD July	May by					

Physician //Medical Examiner A_BERT MARRISON	Specify: Black 16b. Kind of Business/Industry 1 cident Group (First, Middle, Maiden Sumame) Mae Robinson	eign nits No
Ab. City, Town, or Location of Death Converse Ab. City, Town, or Location Converse	4c. County of Death 3a I + i More 8. Date of Birth, Day, Year) 10d. Inside City Lim	nits No
Second S	B. Date of Birth (Month, Day, Year) 10d. Inside City Lim 10d. Inside City Lim 10d. Ves 2 1 10g. Citizen of What Country? 11d. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Non 1	nits No
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21. Signature of Fugeral Service Licensee 22. Name and Address of Facility 23. Name and Address of Facility 240 Reis Versatory		140
erry favers 5240 heisterstown	~ Bd Baltimore Md 212	4.2
		15
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	or respiratory arrest, Approximate Interval Between Onset and Death	
Physician /Medical Immediate Cause (Final disease or condition resulting in death) Physician /Medical Immediate Cause (Final disease or condition resulting in death) Plue to (or as a consequence of):	days	
Examiner Due to (or as a consequence or): PRELIMINATION ENERMY	only A	
Due to (or as a consequence or):		
Due to (or as a consequence of): TRAVMATIC BRATM Due to (or as a consequence of): TRAVMATIC BRATM Due to (or as a consequence of): TRAVMATIC BRATM Due to (or as a consequence of): d. Due to (or as a consequence of): d. Due to (or as a consequence of):	INJURY weeks	
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Die De	23d. Date of delivery	
Your factories of the f	Month Day Year	
in the past 12 months? Compared to the past 12 months? Compared to th		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?	-
should is been si should in the short in the	1 Yes 2 No 3 Probably 4 Onknot	
The law requires to page 2 should be Completed by	24a. Was an autopsy performed? 24b. Were autopsy findings availal prior to completion of cause of death?	able of
Correction The Correction of t	1 Yes 2 No	
25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 28a. Date of Injury 28b. Time of 28b. Time of 28c. Place of Death	th (Check only one) ome 5 Residence 6 Other (Specify)	
O 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Correct Advancesing Home 1	28d. Describe how injury occurred	
O Tradural 5 Pending (Month, Day Year) Injury Work? Accident investigation M 1 Yes 2 No		
27. Manner of Death Valuar	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
Matural 1 Matural 2 Accident 3 Suicide 4 Homicide 4 Homicide 5 Pending investigation 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a course Month, Day Year Injury Month, Day Year Injury Month, Day Year Injury Month 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a course Month, Day Year Injury Month 1 Yes 2 No Month, Day Year Injury Month 1 Yes 2 No 1 Yes 2 No Year		
Continue of the property of	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)	
and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)	
spepte MD DOOS315K	D JULY 299 2006	>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shownard Gupta 9650 Santiaco No.	D JULY 29th 2006 SUITE 110 AD COLUMBIA NO 2104.	
Shallunnaca GUPTA 9650 SANTI ACO NO. State 31. Date filed (Month, Day, Year) 32. Reflistrar's Signature	204	J
State Registrar AUG 0 1 2006 State Registrar AUG 0 1 2006		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician umon 4b. City, Town, or Location of Death /Medical County of Death Facility Name (If not institution, give street and number) 4c. Examiner B. Date of Birth Month, Day, 9) Birthplace (State or Foreign Gountry)

Naryland **Funeral** 1**/2**M 2□ F Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show treumatic svent, the Medical Examiner must be nutified a 1 Yes 2 □ No Maryland Funeral Director timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a -ond. 12. Was Decedent Ever in U.S. Armed Forces?

1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 2 Married 1 Never Married 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Pages 1 end 2 should be filed within nent of Heelth and Mental Hygiene. ent: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be am 2 Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) item 27 I other 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Importent: If it eny injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Home P.A Joseph Ave. W. North Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failurd. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physician and ground for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Be Completed by 1 Yes 2 No 3 Probably 4 Northnown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificete 1 Yes 2 PNo director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes 2 **Y** No After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Sign were and title of certifier DR. CHANCHAU SINGHIAD

State Registrar

Registrar AUG 0 1 20

31. Date liled (Month, Day, Year)

liver & pool

son who completed cause of death (Item 23a) (Type, Print)

32. Pagistrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 08 Day Year 2:30 AM 2006 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) HEGL+h of FLENBURNIE BL ANNE AFUNCEL MG MARINEY 9. Birthplace (State or Foreign Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Months Days Hours Min. MARYLAND 705-12-6036 1 M 2 PF Yrs. Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No GLEN BURNIE ANNE ARUNDEL MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 101 MAIN AVE., S.W. UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) FLORIST CLERICAL WORKER 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HELEN G. KNAUFF FRANK A. KELLENBERGER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3 BRIARS KNOLLS WAY, HANOVER, MARYLAND 21076 WILLIAM T. HELLER, JR./ SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition AUGUST 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN, MARYLAND LORRAINE PARK CEM. 2006 4 Donation 5 Other (Specify) 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A.
421 CRAIN HWY., S.E., GLEN BURNIE, 21. Signature of uneral S ce Licens MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EMENTIA Due to (or as a consequence of) RONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 🗆 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? GRONARY 24a. Was an autopsy performed? 00 CANCER 1 ☐ Yes 2 ☐ No COLON 1 ☐ Yes 2 No 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 4 Nursing Home 1 Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 5 Pending

Physician /Medical Examiner The law requires that the death certificate be executed

permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Ia m any injury or other traum once.

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

7 is marked other than "natural", or items 236 or 288-1 show traumetic evant, the Medical Evanti sermat be notified at

2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or Iter

Baltimore, Maryland 21215-0036

the Maryland

attending physician and been signed by the s should be detached certificate has irector, page 2 s After thi funeral

Division of Vital Records, P.O. Box 68760

or Attending Physicien:

Diractor: /

within 24 hours after To the Funerel Dire

filled in by

Examine Physician/Medical Completed by Be ٩

Certification:

Medical

IF FEMALE

HISTORY

25. Was case referred to medical examiner?

1 TYes

1 Natural
2 Accident 3 ☐ Suicide 4 Homicide

investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

USHA

29b. Signature and title of certifier

29c. License number

2 🗌 No

29d. Date signed (Month, Day, Year) 2006

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE NO

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State Registrar

1 2006

KENNING



State of Maryland / Department of Health and Mental Hygiene ? () () Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 29<u>,</u> Ju1v 10:55am [™] Raymond Arthur Hennessy, Jr. 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 7513 Gaither Road Sykesville Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Dec. 3, Birthplece (State or Foreign Country)
 XY Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2□F 133-28-2482 65 Yrs Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be nutified at 1 ☐ Yes 2√☐ No Sykesville Funeral Director Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7513 Gaither Road 21784 USA death i Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status XYes 2 □ No I Yes, Give Year or Dates: 1959–61 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Financial Examiner Banking of the state of th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil tment of Heelth and Mental H tent: if Item 27 is marked otl jury or other traumatic even Raymond Arthur Hennessy Enid Gilmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Donna C. Hennessy (Spouse) 7513 Gaither Road Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation |7/31/2006 Sykesville, MD 21. Signature of Funeral Service Licensee PACE Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA(Box 195)
Sykesville, MD 21784 (410)-795-1400 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on ear Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ettending pt for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificete hes but director, page 2 si autopsy performed? 1 ☐ Yes 2 2 No 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 1 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely tilled in by the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 4 entifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sign thre and little of ce all 29d. Date signed (Month, Day, Year) 29c. License number 0, Belvedene Ave. 31. Date filed (Month Day, Year) 32. Angistrar's Signature. State Registra 2006 AUG 0

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		1	For State Registrar	State o	f Maryla		rtment of H			giene-	00	6 24006
	*		Negistral Necedent's Name (First, Middle, La	st)					2. Date of De	ath		3. Time of Death
	Physicia		D	avid H	lartz	Hammers			July	30, ^{Day}	2006 ^{Ye}	5:50 A M
	/Medic Examin	- 48	4a. Facility Name (If not institution, giv	e street and nu	mber)		4b. City, Town, or		ath	4c. (County of E	Death
			Wilson Healthcare				Gaither				ntgo	
	Funeral		5. Social Security Number 6. S 124-22-0191	iex IXIM 2□F	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Mi		th 1 <i>y, Year)</i> 18 19	9. 20 Wa	Birthplace (State or Foreign Country) shington, D.C.
c)h	Director	-	Usual Residence of Decedent						OCCODE	10, 17	.0 110	onda-been, peer
	yland		10a. State 10b. County		10c.	City, Town or Lo	cation					10d. Inside City Limits
:	e Ma Sa-f s	cto	Maryland Montgom	ery		Gaith	nersburg					1 X Yes 2 □ No
:	Vith th	Directo	10e. Street and Number 330 Russell Avenu				10f. Zip Code 2087	7			en or wha ed Sta	t Country?
	na 23g	Funeral	11. Maritaf Status	12. Was Dec	edent Ever in	n U.S. 13. V	Vas Decedent of Hi				4. Race - /	American Indian,
0	r iten		1 ☐ Never Married 2 ☐ Married	Armed Fo	orces?	'	Yes, specify Cuba	n, Mexican, Pu	erto Rican, etc.)			White, etc. White
20	filed within 72 hours after death with the Maryland Hygiene, Hysine the The 13a or 28a-f show the then "neturel", or itema 23a or 28a-f show ent, the Medical Examinet must be notified at	1 by	3 Widowed 4 □ Divorced	Year or E	oates: WW		Yes 2 No	<i>Specity</i> :				
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2	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last					18. Mother's N	lame (First, Middle	, Maiden .	Sumame)	
/lar	uld be Vienta Irked Itic ev	ToB	William S. Hamme	rs					Sadie Ha			
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene 1. Health and Mental Hygiene 1. Health and Mental Hygiene 1. I smarked other traumatic event, the Medical Examinating the multiple at the medical Examination other traumatic event, the Medical Examinations.		19a. Informant's Name/Relationship		_		g Address (Street a					
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000	ages int of h t: If ite		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		State		sition (Name of natory or other plac Crematorium		ust 1,			, Maryland
Baltimore,	permit. Pages Department of h Important: If ite any injury or or once.	i	21. Signature of Funeral Service Like		[ES			Mary and the second				vy Chase, Inc.
ñ	Depariment Department of the poores	- 11	MuletaRe	unist	MO	01305 75	oert A. Pum 57 Wisconsi	n Avenue,	Bethesda,	Maryl Maryl	and 20	0814-3501
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oʻ	e exec ian an irial-tr	Exa	resulting in death) Last		(or as a con	sequence of):						
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Division	or Att	Certification:	3 Suicide 6 Could not determined	200. Flat	ce of Injury ding, etc. (Sp		reet, factory, office			(Street and own, State)		or Rural Route Number,
u	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier 1 Certifying P	hysician: To th	ne best of my	knowledge, deat	h occurred at the tir	ne, date and ol	ace, and due to the	e cause(s)	and mann	er as stated.
	Hose Hose	Medical	(Check only 2 Medical Exa	miner: On the	basis of examiner stated.	mination and/or in	vestigation, in my o	pinion, death o	ccurred at the time	, date and	place, and	d due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		1	,	29c. Licens	e number	101	29d. Dat	signed (f	Month, Day, Year)
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	3071		30. Name and address of person was	completed can	use of death	(ftěm 23a) (Type,	Print) USSCL F	tre. 6	Saithers	ourg.	M	
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		•	For State Registrar	State of Mary			rtment of H tificate of L		d Menta		ene 2 0	06	24007
			Decedent's Name (First, Middle, Last,)					2. Date	of Death	Day	Year	3. Time of Death
	Physicia /Medic		Elizabeth	Regina I	Helm				Jul		, 2006		12:56 P M
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, or		eath		4c. County	of Death	
ψ. · .	AG.		Carriage Hil 5. Social Security Number 6. Security		n yrs. last birtl	hdayl	Betheso	a If Under 24 H	Irs. 8. Date	of Birth	Monte		y place (State or Foreign
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	with t	٥	10e. Street and Number 8932 Battery Place				20814				nited		,
	ne 23	Funeral Director	11. Marital Status	12. Was Decedent Eve	or in U.S.	13. V	Vas Decedent of H Yes, specify Cuba		(Specify Yes		14. Rac	e - Ameri	ican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other traumatic event, I'm Mudical Exacilinat ment he notified at Once.	þ	1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		1	rYes, specify Cuba I□Yes 21□No	Specify:	ieno Rican, e	itc.)	Specify	k, White	iite
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چ	should ad Me mark matic	2	George Haslam 19a. Informant's Name/Relationship (T)	vpe, Print)	19b.	Mailin	g Address (Street					State, Zi	p Code)
Z	nd 2 s ulth ar 27 is r trau		Elizabeth Anne He	1m/Daughter	r 89	32	Battery	Place,	Bethe	sda,	Maryla	nd	20814
re,	item item		20a. Method of Disposition		cemeter	y, cren	sition (Name of natory or other place	θ) Ju	1y 28,	20	Oc. Location -	City or T	own, State
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rds	quires in sign uld be								_	1 🗌 Yes	2 □ No	3 Pro	bably 4XUnknown
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	01		30. Name and address of person who o										
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		4	For State	State of Ma	ryland		artment of F				1	2006	24008
			Registrar 1. Decedent's Name (First, Middle, Las	e1		Cer	lilicate of	Deau		Date of Dea	Reg. No≨ ath	- 0 0 0	3. Time of Death
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	28a-	Director	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Co	ountry?
-	3a or		1703 McAuliffe	Drive			2085	1			Unit	ted Sta	ites
	death	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S	3. 13.	Was Decedent of h	lispanic C	rigin? (Specifi an, Puerto Ric	y Yes or No- an, etc.)	- 1	4. Race - Ame Black, Whit	
9	or its	F	1 Never Married 2 Married	1 Karyes 2 □ N If Yes, Give W Year or Dates: W	NO JUJ TT		1 □ Yes 2 🏝 No	Specif	y:			Specify: W	White
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0	iges 1 it of the it it is or ot		1 ☐ Burial 2 🖾 Cremation 3 ☐		Ce	metery, cre	matory or other pla Crematori		July 27	2006			Maryland
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\leq	S S T	OB	examiner? 1 ☐ Yes 2 🖾 No	Hospital: 1 ☐ Inpatio	ent 2	ER/Outpatie	nt 3 DOA	ther: 4	Nursing Home	5 ₺ Resi	dence	6 □Other (Spe	ecify)
n of	ding Phy h. After thi funeral	n: T	27. Manner of Death 1 2Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury	W	ork?	_	d. Describe	how injur	y occurred	
Sio	Attanding r death. actor: Atler by the fune	catio	2 Accident investigation 3 Suicide 6 Could not be]Yes 2		f Location /	Street an	d Number or 9	Rural Route Number,
Division	i or Attan after deat Director:	Certification:	4 Homicide determined		tc. (Specif	ome, farm, s y)	treet, factory, office	•	20	City or To	wn, State)	nurai rioute reinicei,
	Hospital 24 hours a Funeral tely filled		29a, Certifier 1 ☐ Certifying P	hysician: To the best	t of my kno	wledge, dea	th occurred at the	time, date	and place, an	d due to the	cause(s)	and manner a	as stated.
	To the Hospital or / within 24 hours after To the Funeral Direction plately filled in b	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner st	of examina	tion and/or i	nvestigation, in my	opinion, o	death occurred	at the time,	date and	place, and du	ie to the cause(s)
	To the I within 2 To the I complet	M	29b. Signature and title of condition	7/	Da			nse numbe 61083			29d. Da	te signed (Mor	nth, Day, Year)
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0.00	V -		Paul M. Thambi,	M.D. 9/07	Med: trar's Signa	ical C	enter Dr	TAG,	# 3 00,	KOCKV:	ттте	, maryl	ənu
100	St Regist	ate rar	AUG 0 1 2	32. Figist	un.	B A	posti						

			For State Registrar	State of M	aryland / Depa <i>Cel</i>	artment of H		, 0	ene 006	24009
	* 5		1. Decedent's Name (First, Midd	e, Last)				2. Date of Death		3. Time of Death
8	Physici /Medio		JOHN L. HOE	RL				Month JULY	27, 2006	4:55 A.M
	Examir		4a. Facility Name (If not institution			4b. City, Town, or	r Location of Death		4c. County of Death	
			8321 PLEASANT	PLATNS ROAD		TOWS	ON		BALTIMO	RF.
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9 Birth	place (State or Foreign intry)
	Director		218-18-0422	1 🛣 M 2 🗆 F	80 Yrs.			2/22/19		RYLAND
	pug *		Usual Residence of Decedent 10a, State 10b, County	,	10c. City, Town or Lo	ncation				10d. Inside City Limits
	sho	'n								1 ☐ Yes 2 XNo
	he N	Director	MD BA	LTIMORE	TOWS			10	g. Citizen of What Cor	
	with a or	늅		DI ATMG DOAD		10f. Zip Code	20/	10		antry :
	eath	era	8321 PLEASANT	12. Was Decedent	Ever in U.S. 13		286 Ispanic Origin? (Sn	necify Yes or No-	USA 14. Race - Amer	ican Indian
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23s or 28s-f show imatic event, the Mcdical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	ned Forces? 1 X Yes 2 □ If Yes, Give	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
5-0036	t hou			nt's Education	WWII 16a. Dece	dent's Usual Occup	ation	1	6b. Kind of Business/l	ndustry
15	nn 77	plet		st grade completed)	(Give	kind of work done of DO NOT use retired	during most of work	king		,
2	Jiene Frtha	Completed	10TH GRADE	College (1-4or		RPENTER			CONSTRUCT	ION
ğ	othe	Bec	17. Father's Name (First, Middle,				18. Mother's Nam	e (First, Middle, M	aiden Sumame)	
Maryland	uld be Aental riked o	To E	CHRISTIAN F.	HOERL			MARGAF	RET BYRNE	S	
ary		-	19a. Informant's Name/Relations	ship (Type, Print)	19b. Mailin	ng Address (Street	and Number or Rui	ral Route Number,	City or Town, State, Zi	ip Code)
	s 1 and 2 if Health a ltem 27 ls other trai		LELIA HOERL/WI	FE	832	PLEASAN'	T PLAINS	ROAD TO	WSON , MD	21286
altimore,	m O		20a. Method of Disposition	2 🗆 🗖	20b. Place of Dispo cemetery, crei	nsition (Name of matory or other place	ce)	Date 2	0c. Location - City or T	own, State
Ĕ	Pages nent of ant: If It		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5			DGE CEMET	1	1/2006 F	IKESVILLE,	MD
a	permit. Page Department Important: If any Injury of	-	21. Signature of Funeral Service	Licensee					N FUNERAL I	
m	80 5 5 8	2 . 1	1		1	3521 LOCH	RAVEN BL	VD. TOWS	ON, MD 21	286
F			23a Fart: Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final	only one cause on each I	ne.		^		st.	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		tatic ade	10 carcin	ome of	colon		Months
Lai	Examiner			Due to (or as	a consequence of):		·			
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	be K. Isan	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S						
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8760	licate be executed physicien and streems the burial-transit	dical		d						
9	tificat g ph) as th	0								
Box	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			23d. Date of deliv	<i>ч</i> егу
	deat	icla	in the past 12 months? 1 Yes 2 No	4 Pregnant a		Other (specify)			Month	Day Year
о. О	that the de led by the a detached t	hys	9 🗌 Unknown	9□ Unknown						
	igned be del	by F	Part II. Other significant conditi	ons contributing to death t	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Ď	w require been sign	ed						1 🗌 Yes	2 □ No 3 □ Pro	bably 4 Unknown
Records,	law re as be 2 sho	Completed						24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
	The laste has page ?	E						autopsy perform 1 Yes 2	ed? death? XNo 1 ☐ Yes	
Vital	icien; Th certificate rector, pag	BeC	25. Was case referred to medica	1			26. Place of Deat	th (Check only one	Y	
	nysicien; nis certific director,	To	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 🔲 Inpati	ent 2 ER/Outpatier	nt 3 DOA Oth	er: 4 🗌 Nursing Ho	ome 5 Residen	ice 6 Other (Spec	ify)
Division of	ding Ph h. After thi funeral		27. Manner of De th	28a. Date of Inju	28b. Time of Injury	28c. Injun Worl	y at	28d. Describe how	v injury occurred	
<u>Ö</u>	endir sath. or: Al	atle	€ Accident invest	gation			Yes 2 □No			
ž	l or Attendated after death	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 256. Place of In	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Stree City or Town,	et and Number or Rur State)	al Route Number,
	irs aff	Se								
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, I	edical	Check only 2 Medical	ng Physician: To the best Exeminer: On the basis of	of my knowledge, death	h occurred at the tim	ne, date and place, pinion, death occur	and due to the cau	use(s) and manner as	stated. to the cause(s)
	the l hin 2 the l nplet	Med	Oney	and manner st	ated.					
	viti Con	-	29b. Signatule and title of certific			29c. License		29	d. Date signed (Month.	- 4
ř	1.1		- June	10			17041	- 4	7 July	7000
	1011		30. Name and address of person	who completed cause of	death (Item 23a) (Type,	Print) CL	20 1.	y II	10 310	62
132		•	Marc I. Leave 31. Date filed (Month, Day, Year	32. Begist	os York R ar's Signature	DOIGH - STR	30. LA	THEN !!	My 210	٦.5
	Sta Registr		ALIG G	1 2006	H A	parte				
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26, 2006 **Physician** Month David Walter Harthausen JULY 7:58 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson 5. Social Security Number 213-16-4133 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Marry) and **Funeral** 8. Date of Birth Noventh, 40 Year 921 1**X** M 2□ F 84 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location **ehow** 10d. Inside City Limits the Medical Examiner must be nutified at Baltimore Baltimore Md. 1 Yes 2 No Be Completed by Funeral Director or 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 2620 Windsor Road or fteme 23a 12. Was Decedent Ever in U.S. Armed Forces? 1∆Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be tiled within 72 hours after nent of Health and Mental Hygiene.
ent: If Item 27 ie merked other then "naturel", or Itel ury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlotte Becker Ferdinand Harthausen 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2610 Windsor Rd. Baltimore, Md. 21234 Mr. Gary Harthausen/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 8-1-06 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. Towson, Md. ^{22. Na}Ruck^{ad}rows^Forl^{hy}Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Sqheral Service Licenses 23a. Part1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Doset and Death Immediate Cause (Final **Physician** CARDIOPULMONARY ARREST disease or condition resulting in death) 1 HOUR /Medical Due to (or as a consequence of): Examiner SEPSIS <24HOURS Secuentially late and tions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit ASPIRATION PNEUMONIA <24HOURS physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ESOPHAGEAL DISMOTILITY Physician/Medical MONTHS for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ nis certificate has been signed director, page 2 should be PARKINSON'S DISEASE 3 Probably 4 Unknown Completed 1 ☐ Yes 2 ☐ No DEMENTIA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2600 D 32717 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERNANDO DELGADO M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 32. R Flrar's Signature 31. Date filed (Month. State 1 2006

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** July 27, 9:48 A M 2006 Dennis John Hopkins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 64 Yrs. Maryland 220-38-6784 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-1 ehove eny piqury or other traumatic event, tra Medical Exercitar must be notified at 90c8. 1 ☐ Yes 2 🔀 No Lutherville Directo Baltimore Md. ennis Hopkins 7/27/07 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number 1545 Pickett Road 21093 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 □ No 1960 – If Yes, Give Year or Dates: 1964 1 ☐ Never Married 2 ☐ Married Baltimore, Marylahd 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Electrical Engineer <u>Engineering</u> 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be <u>Virginia E. Witzke</u> ည Melvin E. Hopkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1545 Pickett Road Lutherville, Maryland 21093 Mrs. Charlotte A. Hopkins/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State Date 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grd. 7/31/06 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licen 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) montro Coancer Physician UNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Division of Vital Records. cate has been signal page 2 should be 1 X Yes 2 □ No 3 □ Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No Air. ar death. Arector: After this ceru... the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Other: 4 Nursing Home 5 Residence 6 Apther (Specify) NOS PIU Medical Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident hours efter deat meral Director: 3 ☐ Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in I

24 hours e Euneral I

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vithin 2

29a. Certifier (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Boronne us znoy

29d. Date signed (Month, Day, Year)

Uly 27 2006

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

V58303

CHAVIRS MO 6601 Nichola

31. Date filed (Month, Day, Year) AUG 0 1 2006

Registrar

			1_ State	State of Marylar		artment of H			000	21012
		_	Registrar 1. Decedent's Name (First, Middle, Last)			incate or i	Jean	2. Date of Deat	ng. No.	3. Time of Death
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	/Medic Examin		4a. Facifity Name (If not institution, give st			4b. City, Town, or	Location of De		4c. County of De	
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	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 H		Year) 9. B	irthplace (State or Foreign Country)
	Director		210 10 0030	M 2□F 88	Yrs.	WOTHITS Days	Tiodis III	Jan. 26,	1918 Ma	ryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Manyli f eho	ō	Md. Baltimore		rkville					1 ☐ Yes 2 ☑ No
	the 28a	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What C	Country?
	death with the Maryland me 23s or 28s-f ehow rmust be notified at		1811 Rushley Road			2	1234			USA
	deati	Funeral	11. Marital Status	2. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Decedent of H	spanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Arr Black, Wh	
õ	within 72 hours after ene. then "naturel", or ite		1 Never Married 2 Married	1 (XYes 2 □ No ff Yes, Give		I ☐ Yes 2 🕱 No		ono moan, oron		White
12-0036	ure!',	d by	3 Widowed 4 Divorced	Year or Dates:						
ç	"nat	ete	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usuaf Occup kind of work done o DO NOT use retired	during most of v	vorking	16b. Kind of Busines	s/Industry
717	withi ene.	Completed	Elementary/Secondary (0-12)	Colfege (1-4or 5+) 5+		neer	,		Defense	
	be filed within 72 hours after death with the Marylar lat Hygiene. Id other then "naturel", or fleme 23s or 28s-f ehow other then "naturel", or fleme 23s or 28s-f ehow event. Its Medical Examinar must be notified at	60	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle, A	faiden Sumame)	
yland	Mental Mental rked ric ev	To B	Louis K. Hennigha	usen, Sr.			Kath	erine Gei	bel	
Mary	12 should be filed within "h and Mental Hygiene. 7 is marked other then "ireumatic event, the Me.		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street	and Number or	Rural Route Number,	City or Town, State,	Zip Code)
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ore	ges 1 and 2 should it of Health and Men if item 27 is marke or other treumatic		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Re	moval from State	emetery, cren	sition (Name of natory or other place			20c. Location - City of	
Baitimor	tment tent:		4 ☐ Donation 5 ☐ Other (Specify)	Pai		Cemetery		3-06	Parkville	e, Md.
g	permit. Pages 1 Department of H Importent: If ite eny injury or ot once.		21. Signature of Funeral Service License		22	Ruck Tows	son Fund	eral Home, owson, Md.	Inc. 21204	
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8/PU	certificate be executed adding physician and use as the burial-transit									
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ŏ	death certific attending p	Z .	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna		IC			23d. Date of d	elivery
מ	deati	hysician/Me	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		lEctopic pregnancy Other (specify)			Month	Day Year
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Š,	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions cont	ributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tob		to the cause of death?
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ê	has has	ig m						24a. Was ar autops perform	1 24b. Were a prior to ged? death?	autopsy findings available completion of cause of
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VII	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 No Ho	ospital: 1 Inpatient 2	ER/Outpatien	Othe		Death Check only one Home 5 Reside	*	
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0	ath. r: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monat, Day rear)	Injury		Yes 2 □ No			
UNISION	r Atte	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At his building, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (Str City or Town	reet and Number or F , State)	Rural Route Number,
)	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	O								
	Hosi 24 ho Fund Hely fi	edical	29a. Certifier (Circle only one)	cian: To the best of my knows. On the basis of examina and manner stated.	wiedge, death ition and/or inv	occurred at the time of time of the time of time of the time of ti	ne, date and pla pinion, death oc	ice, and due to the ca courred at the time, da	use(s) and manner a ite and place, and du	is stated. lie to the cause(s)
	o the	Med	29b. Signature and title of certifier	and maining stated.		29c. License	number	29	d. Date signed (Mor	oth, Day, Year)
}	r s r ŏ		Jow Blue	& mos		0006	1190		July, 30,	2006
	ntl		30. Name and address of person who con	aplated agues of death (free	n 23a) (Type,	Drint)				
_/	25		Jason Black, 656.	5 dout Chav	65 St,	Scite 20	7. Tow.	son mi)	21204	
	Sta Registr		Jason Black, 656. 31. Date filed (Month, Day, Year) AUG 0 1 200	32. Segistrar's Signa	Tuly A	asset !				

			State of Maryland / Dep				2006	01.012
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of l	Death	Reg 2. Date of Death	. No 2 U U D	3. Time of Death
	Physicia	ın				July 28	2006 Year	7:00 A ^M
	/Medic		Dwight W. Hammond 4a. Facility Name (If not institution, give street and number)		r Location of Death	oury 20	4c. County of Death	7.00 A
	Examin	er	5503 Williams Road	Hydes			Baltimore	2
1 4	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	y) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9 Rintho	lace (State or Foreign
	Director		218-09-8730 1 ¹ X M 2□ F 90 Yrs.	Months Days	Hours Will.	May 30,1	916 Mary	land
	p ,	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			1	Od. Inside City Limits
	aryian show	5						1 ☐ Yes 2 X ☐ No
	the M	Directo	Maryland Baltimore Hydes	10f. Zip Code		100	J. Citizen of What Coun	try?
	with Sa or		5503 Williams Road	21082			U.S.A.	
	me 2:	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	3. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ Black, White,	
9	or Ite		1 □ Never Married 2 □ Married 1 □ Yes 2 M No ff Yes, Give	1 ☐ Yes 2¥☐ No	Specify:	nican, etc.)	Specify	
200	J within 72 hours after death with the Maryla plene. Itan. "natural, or Itams 23a or 28a-f shov the Medical Exertiting to use the intilitied at	d by	3 X Widowed 4 □ Divorced Year or Dates:				wn	
<u>.</u>	72 h natu	Completed	(Specify only highest grade completed) (Given	cedent's Usual Occup ve kind of work done o b. DO NOT use retired	during most of work		6b. Kind of Business/Inc	dustry
12	within ane. than	mc	Elementary/Secondary (0-12) College (1-4or 5+)	ership Dir	•	С	hamber of (Commerce
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. the than 'natural', or Items 23s or 28s-f show off, the Medical Examiner must be natified		17. Father's Name (First, Middle, Last)	CI SILIP UTI		e (First, Middle, Ma		
au	m = 0 \$	To Be	Walter Hammond			Fannie	Casse	1
ary	2 should be filed v and Mental Hygie is markad other t raumatic event, ID		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street	and Number or Rui	al Route Number, (City or Town, State, Zip	Code)
	and 2 salth a n 27 is			Oak Hill		nton, Geo		
altimore,	of He of He if item		20a. Method of Disposition 1 ★ Burial 2 Cremation 3 Removal from State Triffic Cremation 3 Removal from State	position (Name of rematory or other place Long Greet		Date 20	Oc. Location - City or To	wn, State
Ĕ	Pages ment of tant: if it		4 Donation 5 Other (Specify) Episcop	al Church	Cem.8-2-	2006	Hydes Mar	ryland
Bail	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic e DOC.			22. Name and Addre	Ru	ck Towson	Funeral Ho	ome, Inc.
	005 e a		23a. Part 1. Enter the disease, or complications that caused the death. Do not e	1050 York		owson, Ma		Approximate
			shock, or heart failure. List only one cause on each line.	miler the mode of dyn-	rg, such as carolac	or respiratory arres	,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	4				
	Examiner		Due to (or as a consequence of):	1B Dom	UNAL	Chm.	PHMA.	3 TEARS
		Jer	Sequentially list sundriums, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			(/		
	outed od ransit	Examin	that initiated events					
Ó	e exe	EX	resulting in death) Last Due to (or as a consequence of):					
8760	cate be executed physician and the burial-transit	dical	d					
9	seath certifica attending pl	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		7.77		23d. Date of delive	201
Вох	attend for us	Physician/Me	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	у		Month Month	Day Year
o.	that the de ed by the detached	yslo	1 Yes 2 No 9 Unknown					
s, T	The law requires that the death certific at has been signed by the attending page 2 should be detached for use as	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	a underlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
rds	w requires been sig should be					1 🗆 Yes	2 No 3 Prob	ably 4 Unknown
000	aw requisible been 2 should	Completed				24a. Was an autopsy	24b. Were auto	psy findings available impletion of cause of
ž		E O				perform	ed? death? No 1 ☐ Yes	
ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?			th (Check only one)	
of Vital Record	Q S	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	tient 3L DOA			ice 6 Other (Specif	y)
Ž	ling P	lon:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time fnjur	y Wo	ryat rk?]Yes 2 □ No	28d. Describe hov	v injury occurred	
Division	Attending or death. ector: After by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of fnjury - At home, farm,		,		eet and Number or Rura	al Route Number,
S	after Direct	Certification:	4 Homicide determined building, etc. (Specify)	,,		City or Town,	State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de					
	the Ho hin 24 I the Fu	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.					
	To the within 2 To the complet	Σ	29b Signature and title of continer	29c. Licens	se number	29	d. Date signed (Month,	
•	~		Million Date of the second	0	21.11		of all	21047
	10		30. Named and aggreess of proson with sample and some death (flein 23a) Type	pe, Print)	112 /2	MA ARA	1 LAND	21047
	,	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	FITH	USYUN	W CANO	n vitil V	
	Regist		AUG 0 1 2006 Augus 18	Coretie)				

U6-U551/ Please Type or Print in Black Indelible Ink Joseph Franklin Joy, Jr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Year 1630 hrs **Medical Examiner** July 28, 2006 Joseph Franklin Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7730 Baltimore & Annapolis Boulevard Anne Arundel Glen Burnie If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Director Country) 212-34-6497 1X M 2 F July 14,1936 70 Yrs MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits À 1 Yes 2 X No 28a-f show l other thau "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once. MD Anne Arundel Glen Burnie Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' U.S.A. 212 6th Avenue NE 21060 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White etc. 1 Never Married 2 X Married White If Yes, Give Year 3 Widowed 4 Divorced Yes 2X No specify: Specify ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 7 Superintendant Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) marked event, Joseph Franklin Joy Sr. Florence Irene Hardesty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it. Pages 1 and 2 shoul riment of Health and Martant: If item 27 is my or other traumatic ey Mrs. Muriel Virginia Joy/Wife 212 6th NE Glen Burnie, Maryland 21060 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State August 1, permit. Page:
Department of
Important: 1
injury or othe Cedar Hill Cemetery 2006 Donation 5 Other Specify Brooklyn, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061 MO1357 ark Vancere Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** re. List only one cause on each line Between Onset and /Medical Death a Compressional Asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medica 26.Place of Death (Check only one) To the Hospital or Attending Physician: completely filled in by the funeral director Be examiner? Hospital: 1 Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene After this 1 V Yes No 28a. Date of Injury Jul 28, 2006 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject trapped by earthmover 1615 hrs Natural 1 ✓ Yes 2 No Pending death within 24 hours after death To the Funeral Director: 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined (Specify) Construction Site 7730 Baltimore & Annapolis Boulevard, Glen Bur Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 29, 2006 30. Name and address of person who completed cause of death (Item 23a) David Fowler M.D. Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, AUG 0 32. Registrar's Signature State 2006 Registrar all alice

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Marvin Leonard Johnson, July 27, 2006 7:30 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1209 Mill Creek Road Fallston Harford If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1**⊠** M 2□ F Yrs. 212-05-4935 91 1914 Canada Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d, Inside City Limits 10a. State 10b. County r than "naturel", or Iteme 23a or 28e-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Maryland Harford Fallston Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1209 Mill Creek Road USA 21047 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after dital Hygiene. dother than "naturel", or Item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Special Investigator Utility 11 Pages 1 and 2 should be filed w treen of Health and Mental Hygie tant: If item 27 is marked other t ijury or other treumatic event, in 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louis Oscar Johnson Zula Arvada Kessinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1209 Mill Crock Road, Fallston, Maryland 21047
of Disposition (Name of Date 20c. Location - City or Town, State Paula R. Johnson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Removal from State permit. Page Department of Important: If eny injury or once. Mountain Christian 7-31-06 Joppa, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that coused the dishock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ancel **Physician** word 2 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (ur as a consequence of) Examine ing physicien and E The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2♥ No certificate has tirector, page 2 s 1 Yes 2 **2** No or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient ို 2 ER/Outpatient 3 DOA After the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 2 Accident 5 Pending 1 Yes 2 No death investigation I Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELAK, MD 21014 S. ATWIND 602 MYO THAM 31. Date filed (Month, Day, Year) egistrar's Signature State AUG 0 1 2006 Registrar

		•	For State Registrar	State of Ma	aryland /		rtment <i>tificate</i>			ınd Me		giene Reg. No.	006	24016
	Physicia	an	1. Decedent's Name (First, Middle, Last)	5. 5	Tohns	SOV					Date of Dea Month 2.		006 Year	3. Time of Death 11:27 A M
	/Medic Examin	al	4a. Facility Name (If not institution, give s				4b. City, T	own, or SVIL	Location o				County of Death BALTIM	
	Funeral Director		213 40 0207 A	7. Age M 2□F	65 (In yrs. last bi	rthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	Date of Birtl (Month, Day MAY 4,	v. Year)	Cou	place (State or Foreign ntry) MD .
	aryland show	J.	Usual Residence of Decedent 10a. State 10b. County MD . BALTIMOR	ਰ	10c. City, Tov			ED.						10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	r 28e-f	irecto	MD. BALTIMOR	.L.	<u> </u>	דחחד	E RIV					10g. Citiz	zen of What Cou	
	23a o	raiD	305 RETFORD WAY,	APT. H					1220				TED STAT	
920	be filed within 72 hours after death with the Maryland tal Hygiene and extending the most result be notified at event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give X Year or Dates:			Vas Decede Yes, specif I Yes 2	v	spanic Origin, Mexican Specify:	gin? (Speci i, Puerto Ri	ly Yes or No- can, etc.)		14. Race - Ameri Black, White, Specify: WI	
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a	(Give	lent's Usual kind of work	done di	uring most	t of working		16b. Kir	nd of Business/Ir	ndustry
21215-0036	giene. er then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		SUPER	,				ST	ORAGE FA	ACILITY
land	should be filed nd Mental Hygi marked other imatic event, II	To Be (17. Father's Name (First, Middle, Last) RAYMOND P. JOHNSON							,	First, Middle, R. RUI			
Maryland	ges 1 and 2 should tof Health and Men If item 27 Is marke or other treumatic		19a. Informant's Name/Relationship (Ty); FRANCES JOHNSON/WI				-						r Town, State, Zij RIVER, N	Code) 21220 MARYLAND
	es 1 an of Heal f item 2 r other		20a. Method of Disposition		20b. Place	of Dispo		e of		Dai	The state of the s		cation - City or T	
Baltimore,	Pa nen ent: ury		1 [♠] Burial 2 ☐ Cremation 3 ☐ R • 4 ☐ Donadon 5 ☐ Other (Specify)	emoval from State	DULAN					7/29/0				MARYLAND
Bal	permit. Departi Importi any inj		21. Signature of Fineral Service	2										SON, INC. ND 21224
			28a. Part 1. Enter the disease, or compli- enock, or heart failure. List only or Immediate Cause (Final	cations that ceused ne caus n each li	I the death. Do	not ent	er the mode	of dying	, such as	cardiac or	espiratory ar	rest,		Approximate Interval Between Onset and Death
+	Physician / /Medical		disease or condition resulting in death)	i	a consequence	of):	Jail	ire				`	-	1 note
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8760,	ate hy:			1										
O. Box 6	The law requires that the death certific that been signed by the attending pixes 2 should be detached for use as it.	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal deat		Ectopic pre Other (spe					2	23d. Date of deliv Month	ery Day Year
۵	quires that in signed by uld be deta	by P	Part II. Other significant conditions con	ntributing to death b	ut not resulting	in the u	nderlying ca	use give	n in Part I.		23e. Did to		se contribute to t	the cause of death?
Vital Records,	(G L	Completed									24a. Was autop perfor 1 Yes		24b. Were autoprior to codeath?	opsy findings available ompletion of cause of
Vita	Physicien: 1 this certificat ral director, p	o Be	25. Was case referred to medical examiner?	lospital:	all spic			Othe			Check only o	-	CO	4.1
of	Jing After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ent 2□ER/C ry y Year) 28b.	Time of Injury		Bc. Injury Work	at	28	d. Describe h		Other (Speci y occurred	ny)
Division	spital or Attendi ours after death. ierel Director: A filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, c. (Specify)	farm, str	eet, factory.	office		28	f. Location (S City or Tow			al Route Number,
	HOS FL Bly	edicai C	29a. Certifier Certifying Physical Conduction (Check only one)	ner: On the basis o	f examination a	nd/or in	vestigation,	in my op	inion, dea	th occurred	at the time,	date and		
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c.	License	number	- 0		29d. Date	e signed (Month,	Dey, Year)
	1			umplated course of	looth /ltor- 00-	\ (Tue -	Prin*1	DE	17	3/			7/20	5/06
-	H		V	and manner st	10/9/05	, (туре,	rank	1/h	59	gr.	Ste 3,	12	Balta	1237
	Sta Regist		31. Date filed (Month, Day, Year) AUG 0 1 200	32. egistr	ar's Signature	14	ale		U					

			_ State		artment of Health and		21116	24017
			Registrar 1. Decedent's Name (First, Middle, Last)		runcate or Death	2. Date of Death	. No	3. Time of Death
	Physicia		James Keit			July	Day Year 2006	6:59 AM
	/Medic Examin		4e. Fecility Name (If not institution, give street a	nd_number)	4b. City, Town, or Location of Dea		4c. County of Dea	
	_ Xa	•	Union Memorial	Hospital	Baltimore C	ity	NA	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr Months Days Hours Mir	. (Month, Day, Y	ear) Co	thplace (State or Foreign
	Director		239-56-4174 Usuel Residence of Decedent	68 Yrs.		09/16/19	37	SC Scriving
	land ow		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	Mary Fr sh	tor	MD N/A	Baltime	R.			1 X Yes 2 □ No
	h the	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Co	ountry?
	23a c		4913 Nelson Av	e,	21215	L	ISA	
	tem tem	Funerai	Am	s Decedent Ever in U.S. 13. ned Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	
36	4 within 72 hours after death with the Maryland jiene. t than "natural", or flama 23a or 28a-f ahow tra Mudical Examinar must be matified a	by Fi	If Y]Yes 2⊠No es, Give ar or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Q	-
21215-0036	tural stural	edt	15. Decedent's Education	16a. Dece	edent's Usual Occupation	16	b. Kind of Business	(Industry
212	within 72 ene. then "na	Completed	(Specify only highest grade comp	leted) (Given life.	e kind of work done during most of w DO NOT use retired)	orking		
7	filed with Hygiene. other ther	Com	11th Grade	. 1 4	pervisor		Onstruc	tion
nd	d la b	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	ime (First, Middle, Ma		
Z a	should to a marked umatic a	ဥ	hobert Keith	-40- 44-1	Willie		gers	To Code)
Maryland	d 2 th a 7 Le		19a. Informant's Name/Relationship (Type, Pri	1	ling Address (Street and Number or F		nly or rown, state, .	zip Code)
ē,	s 1 and 2 if Heelth Item 27 I		20a. Method of Disposition	20b. Place of Disp	osition (Name of	MORE, MD	c. Location - City or	Town, State
MO	0 0 = =		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	from State	ematory or other place)	12006 B	altimase	an
Baltimore,	교육원급 .		21. Signature of Funeral Service Licensee		22. Name and Address of Facility Youth C. Greene Fi		ed HITTO HE	PID
m	Depa Impo any i		Vaughn C. G	reone 3	5157 Balto, Nati T	ike Battir		21229
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do not en e on each line.	nter the mode of dying, such as cardi	ac or respiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	VD STAGE RE	ENAL DISEA	SE		20 YEARS
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	1.10			7 2000
		-	Sequentially list conditions, if any leading to immediate	Due to (or as a consequence of):	1+			+ DAYS
	petr Insit	Examiner	cause. Enter Underlying Cause (Disease or injury					
ó	The law requires that the death certificate be executed to has been signed by the ettending physicien and age 2 should be deteched for use as the burial transit		and the state of t	due to (or as a consequence of):				
8760,	nte be nysicie ne bur	dical	d					
9	ing ph	Med	IF FEMALE:			C 70500		activation seems the district of the seems to be a seem to
Box	eath certific ettending p for use as	lan/	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date of de Month	livery Day Year
<u>o</u> .	t the de by the e teched f	Physician/Me	1 Vas 2 No	Pregnant at time of death 5 Unknown	Other (specify)			,
a	that II		Part II, Other significant conditions contributing	ng to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
sp.	uires sign ld be	d by				1 ☐ Yes	2 □ No 3 □ P	robably 4 Onknown
S	w requir s been si should	lete				24e. Was an	24b. Were a	utopsy findings available completion of cause of
of Vital Records,	The lavelete has	Completed				autopsy performe	dy death?	completion of cause of
ita		BeC	25. Was case referred to medical		26. Place of D	eath (Check only one)	1.00	2010
>	g 5 ig	10	examiner? 1 ☐ Yes 2 📆 No Hospita	1 Vinpatient 2 EH/Outpatie		Home 5 ☐ Residence	e 6 □Other (Spe	cify)
	ing After une	uo.	i Linatarai B Linaraing	Date of Injury 28b. Time (Month, Day Year) Injury	Work?	28d. Describe how	injury occurred	
Division	tten deat ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury - At home, farm, s	M 1 Yes 2 No	28f Location (Stre	et and Number or R	ural Route Number
Ďį	spital or Attand hours after death heral Diractor: / / filled in by the f	Certification;	4 Homicide determined	building, etc. (Specify)	ricot, factory, office	City or Town,		oral Front Works
	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by				ith occurred at the time, date and place			
	To the Hos within 24 h To the Fun completely	Medicai		n the basis of examination and/or i d manner stated.	nvestigation, in my opinion, death oc		·	
	To To Com	2	29b. Signature and title of certifier	nk, H.D	29c. License number		. Date signed (Mont	
	1		-0.10		AT243894	6	uly 30	12006
	H		30. Name and address of person who complete DRAGANA TOM	d cause of death (Item 23a) (Type	NON HEMUR	AL LICIST	PITAL	MD
	Sta	te	31. Date filed (Month. Dav. Year)	32. Registrar's Signature		- 7,00	11/1	110
	Registr		AUG 0 1 2006	32. Registrar's Signature	porte			

State of Maryland / Department of Health and Mental Hygiene 2 0 6 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Monthly Physician 28, 2006 9:00 AM Leonard Liddic Freeman /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center Towson Saint Joseph Medical If Under 1 Year & if Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
Jan 19,1921 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1√2 M 2□ F 202 09 7958 85 Pennsýlvania Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b Count 10a State 28a-f show rthan "natural", or Iteme 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Middle River 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 114 Yawmeter Drive 21220 USA death Funeral 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, Ita Medical and once. Amed Forces? 1/AYes 2 □ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White WWIT Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Tool & Die Maker Manufacturing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Liddic Edgar Leslie Allman Mabel S. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris A. Liddic wife 114 Yawmeter Drive Middle River Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. Aug 2, 2006 Baltimor County Md 4 Donation 5 Other (Specify) 21. Sign ture of F neral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease shick, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition results) in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE LUNG DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed CORONARY ARTERY DISEASE that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown s been signed by the should be detact Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 26. No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate 1 Yes or Attending Physician: After this certifical funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification; To 1 ☐ Yes 2 🔀 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ➡Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the t 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cettifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 D 41410 30. Name and address person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE, TOWSON, MARYLAND 21204 7601 JOGINDER P. M. D. . MEHTA. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 1 LEBEUR. 2006 Registrar

•	4	•	1 - For State Registrar	State of Maryland	•	t of Health and e of Death		ene2 0 0 6	24019
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) ROSALEE LA	VD.			2. Date of Death Month	Day Year 27 200	3. Time of Death
	Examin Funeral Director		211 20 - 8 127	MOSPITAL 7. Age (In yrs. last	RAU	Town, or Location of Dea	S. 8. Date of Birth (Month, Day,	4c. County of Deat SALT/ Year) 9. Birth Co	more (State or Foreign untry), he was s
	Maryland -f show	tor	Usual Residence of Decedent 10a, State 10b, County		own or Location		•		10d. Inside City Limits 1 Yes 2 □ No
	death with the Maryland ima 23a or 28a-f show ir must be notified at	Funeral Director	10e. Street and Number	1. #28	10f. Zig		10	Og. Citizen of What Co	untry?
	urs after deat al', or itama ' Examiner mu	by	11. Marital Status 1: 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Pes 20 No If Yes, Give Year or Dates:	13. Was Dece If Yes, spe 1 \(\subseteq Yes	dent of Hispanic Origin? city Cuban, Mexican, Pue 2 No Specify:	Specify Yes or No- irto Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	od within 72 hours after giene. er then "neturet", or Ita r the Medical Exemilre	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		life. DO NOT u	rk done during most of w	orking	16b. Kind of Business/	-
Maryland 2	should be filed nd Mental Hygin marked other imatic avent, III	To Be C	17. Father's Name (First, Middle, Last)	vie		Na	ame (First, Middle, N	nita	
Baltimore, Mar	s t and 2 Health a tam 27 la		19a. Informant's Name/Relationship (Typ 20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	amoval from State	19b. Mailing Address 201 R e of Disposition (Na etery, crematory or of Disposition)		Cours +		Nas Mills Md
Balti	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeral Service Licenser			nd Address of Facility	inaturan UN Rd B	-Harris to	Md 21215
760,	Physician and // // // // // // // // // // // // //	dicai Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a consequent)	00 01): ATBRY 00 01).	FAILURE	ac or respiratory arre	st,	Approximate Interval Between Onset and Death
.O. Box 68	that the death certificat ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death	ath 3 Ectopic p			23d. Date of del Month	ivery Day Year
Q.	sign d be	þ	Part II. Other significant conditions cont	ributing to death but not resultin		-		acco use contribute to s 2 No 3 □ Pr	the cause of death?
al Records,		Completed					24a. Was ar autops perform 1 ☐ Yes 2	prior to death?	topsy findings available completion of cause of
of Vital	di S	To Be	TI THE ZEMANO		/Outpatient 3 D	OA Other: 4 Nursing		nce 6 □Other (Spe	city)
Division (fing After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred reet and Number or Ru	en I Pauto Number
Οį	To the Hospitel or Attend within 24 hours after death To the Funeral Director; completely filled in by the		4 Homicide determined	building, etc. (Specify)			City or Town	, State)	
	the Hos	Medical	(Check only 2 Medical Examin	ician: To the best of my knowle er: On the basis of examination and manner stated.	and/or investigation	at the time, date and pla i, in my opinion, death oc c. License number	curred at the time, da	ause(s) and manner as te and place, and due	to the cause(s)
)	Vill O C		29b. Signature and title outcarifie	h M.D	25	0 - (00	22		
	3		30. Name and address of person who could have a second sec	INGH 541	310401	OURT ROAD	RANDALL	STOW, BA	LTIMORE
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 1 2	32. Registrar's Signature	H Aparl	w w		,	

		•	For State Registrar	State of Maryland			t of H		lental Hy	giene Reg. No.	2111)6	24020
	Dhuaiai		1. Decedent's Name (First, Middle, Last,						2. Date of Do		56	Year	3. Time of Death 15:07 M
	Physicia /Medic	al	Eileen	Leotta	a	45 0%	T	Lanation of Dooth	July 2		County o	of Dooth	15:07 M
).	Examin	er	4a. Facility Name (If not institution, give Mercy Medical Cen				iltim			46.	n/	/	
	Funeral Director		5. Social Security Number 6. Se 088-22-6133	x 7. Age (In yrs. Id ☐ M 2以F 62	ast birthday) Yrs.	If Unde Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D June 2	ay, Year)		Coun	lace (State or Foreign try) York
	DI .		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation						1	0d. Inside City Limits
	Maryla 1 sho	ō	Delaware Sussex C	ounty	South 1	Betha	any						1 ☐ Yes 2 ☐ No
	with the Sa or 28a	i Director	10e. Street and Number 411 Rebecca Road			10f. Zi	Code 199	30			.S.	hat Coun	try?
36	2 should be filed within 72 hours after death with the Maryland and Mantla Hygiene. Is marked other than "nature!", or Itema 23a or 28a-f ehow aumatic event, the Madical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:	1	Was Dece f Yes, spe	city Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	0-		k, White,	an Indian, etc. ite
8	ture!	ed t	15. Decedent's Edu	ucation	16a. Deced	dent's Usu	ial Occupa	ition		16b. Ki	ind of Bus	siness/Inc	dustry
215	hin 72 nn "nn Medic	plet	(Specify only highest grad	le completed) College (1-4or 5+)				luring most of work)	ing				ryland
2	ed wit ygiene ygiene t, he	Completed	12	5+	Те	ache	r	18. Mother's Nam	o (Final Adiodel)				ge's Co.
/land	uld be fill Vental H Irked oth	To Be	17. Father's Name (First, Middle, Last) Simon	Amsterdam				Ruth	Teller				
Man	and 2 sho alth and I 27 ie mu er trauma		19a. Informant's Name/Relationship (T) John B. Leotta	ype, Print) (Husband)	19b. Mailin	Rebe	s (Street a	Rd., Sou	th Beth	ber, City o nany ,	Del	state, Zip awar	e 19930
Baltimore, Maryland 21215-0036	permit. Pages I and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic evonce.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State R	lace of Dispo emetery, cren yview	natory or	other place	a) _	Date /28/06			-	wn, State Maryland
Balti	permit. Departmit. Importa any inju		21. Signature of Fundal Service Licens	Kevin E Ecl	ker 22 Me 13	Name a CCu1. 30 Ea	nd Addres Ly-Po ast F	lyniak Fuort Ave.	uneral Balti	Home, more	, P./ . Md	A. 21	1230
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death	n. Do not ent	er the mo	de of dyin	g, such as cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death
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<u>ن</u>	eath certificate be executed attending physicien end for use as the burial-transit	/Mec	IF FEMALE:	23c. If yes, outcome of pregna	incv						23d. Date	e of delive	-
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s, P.O	es thet the gned by be detac	by Ph	Part If. Other significant conditions co	intributing to death but not res	ulting in the u	nderlying	cause give	en in Part I.			_		ne cause of death?
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of Vital Record	The law ete hes b page 2 st	Comple			·				24a. Wa aut per 1 Tes	opsy formed?	þ	rior to co leath?	psy findings available mpletion of cause of
/ita	cien: sertific sector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea					
on of	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	lon: To	27. Manner of Death 1 SNatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injun Wor	4 Nursing n	ome 5 Re				y)
Division	or Attendater death Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, str y)					(Street ar		er or Aure	al Route Number,
_	Hospital 24 hours Funeral stely filled	edical C	29a. Certifier 1 SC Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurre	d at the tin	ne, date and place pinion, death occu	, and due to the	e cause(s e, date and) and mai d place, a	nner as s and due to	tated. the cause(s)
	nithin To the	Me	29b. Signature and title of certifier			2	9c. Licens	e number		29d. Da	te signed	(Month,	Day, Year)
	->-0		I Lee le	it mo			1)6	3734		Ju	14.	27.	2006
			30. Name and address of person who		n 23a) (Type,	Print)					-) -		Bultimore
	`		m - C 1/C31m	o Johns	Hopkin	ns t	(osp:	1 600	N. W.	olfe	54	ect	MD 21287
2	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32! Registrar's Signa	ature A	will.							Baltmore MD 21287

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** MASY: 11 30 Yin-chun 2006 /Medical 4c. County of Death 4b. City, I own, ...

The location of the loca 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hopkins Itospital Johns Birthplace (State or Foreign Country) 5. Social Security Number பんに 6. Sex (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F 21 Yrs. Director Taiwan Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23s or 28e-f show iit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla animent of Health and Mental Hygiene.
Intent: if item 27 is marked other than "neturel", or itema 23e or 28e-1 ehov injury or other treumatic event, the Medical Examinar must be notified at 1 XYes 2 No VA Henrico Glen Allen Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12408 Lynwood Dr. 23059 Taiwan Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Married 2 Married 2 Married Specify: Asian Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Student 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zhe-Yan Lai Hui-Lin Chang 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hui-Lin Chang/Mother 12408 Lynwood Dr. Glen Allen VA 23059 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition August 4, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation—5 ☐ Other (Specify) Baltimore, MD Bayview Cremarory permit.
Departr
Importe
any inju 21. Signature : Fun-ral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home unaries L. Stevens Funeral Home Inc. 1501 East Fort Ave Baltimore,MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner lymphoc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Į Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2010 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Umpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Tes 2 No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the h 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and July 30, 2006 RES-000 20 use of death (Item 23a) (Type, Print) 30. Name and address of person who complete Johns Hooking Hospital 600 North Wolfe Street Bellimor MD 21287 William Fischer 31. Date filed (Month, Day, Year) State Socret ! 0 1 2006 Registrar

			For State	State of Marylan		artment of H			2000	21.022
	4	rite.	Ragistrar 1. Decedent's Name (First, Middle,	Last)		tineate of t	Dealir	2. Date of Dea	Reg. No. UU	3. Time of Death
	Physici		1.101.1	040-1 03			,	Month 3	Day Year	
	/Medic Examir	_	4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, o	r Location of Death	2 047 C	4c. County of De	
29.	3		Mai Doza Ruc	(ROAD)		STHUS	FORD		HARF	RO
	Funeral		Social Security Number	Sex 7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti		irthplace (State or Foreign Country)
	Director		431-70-6677	MM 20F 68	Yrs.			MARCH		KANSAS
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	Mary	jo	Occalor Hass	F080 \	245	SFORD				1 ☐ Yes 25 No
	28a notil	rec	10e. Street and Number		20011	10f. Zip Code			10g. Citizen of What (Dountry?
	h with	ai D	1721 OSSA R	UN ROAD		ant	0		11.5.6	
	ems s	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race - An Black, Wh	
98	or It	y Fu	1 Never Married Married	Yes 2 No		1 ☐ Yes 2 No	Specity:	7 110071, 01017	Specify:	113
5-0036	72 hours after death with the Maryland natural', or Items 23c or 28a-1 ehow Iteal Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates: Ko	$A \perp$				W	HILE
215-	in 72	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work	ing K	16b. Kind of Busines	s/industry
212	l within iene. r than *	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	-	zaplo	NSA-01	10000	TRANCA	CATATION
	Hygi other	Be C	17. Father's Name (First, Middle, La	est)	~~~	12. (1 20	18. Mother's Nam	e (First, Middle,	Maiden Surname)	0, ((())
/lar	uld by Wenta Wenta rrked	To E	CARL	rano			(203)	IRE	NE WAG	10
Maryland	toges 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. If item 27 la marked other than "natural", or items 23c or 28a-1 ehow or other treumetic event, the Madical Examinar must be notified at		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Rur	al Route Numbe	r, City or Town, State,	Zip Code) AINO
-	1 and Health Iem 27 other tr		CHRISTING R.	70XD	1737	D275 6	UN KOF	O MH	ILFORD.	MARYLAND
Ore	ges 1 t of H If ite or ot		20a. Method of Disposition 1 Darial Cremation 3		ace of Dispo emetery, crei	sition (Name of matory or other place	(a) Avis	Date	20c. Location - City	r Town, State
Baltimore	Part ner		Donation 5 Other (Spe	11	instru		KET 3	do	LOGOZ HI	TT LINGTEUD
Bal	permit. Departi Importi any inj gnce.		21. sign yure Fun ra Servi). Lic	cen ee	22	Name and Address	as of Eachilly	HUNT	- BEL HIR	199
			23a. Part1. Enter the disease, or co	omrilinations that caused the death	Do not en	OSW HOR	TURIVAL I	-0(67)	HIT LIBE	LAND ANSO Approximate
			shock, or heart failure. List or Immediate Cause (Final	ly one cause on each line.	3 4-	C	g, odon do odraido	or roopilatory an		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. 20NG C	ANC	EX				4 YEARS
r	Examiner			EXTENS	IVE	METAS	TASIS			SMONTHS
	*	ner	Sequentially list conditions, if any, leading to innecitate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience oi):	I CHE III				1.0000
V	xecuted and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· 15L126011	il, C	MSTRIC	METH	SYASIS		42347
60,	sate be executed hysician and the burial-transit	EX	resulting in death) cast	Due to (or as a consequ	sence of):					
8760	icate be ex physician s the buria	dical		d				<u>-</u>		
9 X	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar	ncy				23d. Date of de	olivon
Вох	death atter	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	-		Month	Day Year
P.O.	that the de ed by the detached	hysi	9 Unknown	9□ Unknown					-	
	The law requires that the death certific ite has been signed by the attending p rage 2 should be detached for use as		Part II. Other significant conditions	s contributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	w require been sig should b	ed	12MPHYSIEM	A				1 □ Y	es 2□No 3⊅	Probably 4 Unknown
Records,	law re as be 2 sho	Completed by						24a. Was a autop:	an 24b. Were a	autopsy findings available completion of cause of
<u> </u>		Son						perfor	med? death?	s 2 No
/ita	Physician: The law rthis certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	I de la constantina della cons			26. Place of Deat	h (Check only or	ne)	
of	> 0 0	5	1 Yes 2 No 27. Manner of Death		ER/Outpatier		4 Linuising inc		ence 6 Other (Sp	ecify)
on	ding After fune	tion	1 XNatural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	Worl	k? Yes 2 XNo	280. Describe in	ow injury occurred	
Division of Vital	Attendi death. octor: A by the fu	fica	3 Suicide 6 Could not	t be 28e. Place of Injury - At ho	me, farm, str		- 44	28f. Location (S	treet and Number or F	Rural Route Number,
Ö	all Dire	Certification:	4 Homicide	building, etc. (Specify	·)			City or Tow	n. State)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical (29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my know aminar: On the basis of examinat and manner stated.	wiedge, deati ion and/or in	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the cred at the time, o	ause(s) and manner a late and place, and du	as stated. le to the cause(s)
	To thi within Fo the	Me	29b. Signature and title of certifier		· · · · · · · · · · · · · · · · · · ·	29c. License	e number	2	29d. Date signed (Mor	oth, Day, Year)
			> E/Shanno	MID		D 3	1856		07/28/2	2006
	٠.		30. Name and address of person wh	no completed cause of death (Item	23а) (Туре,	Print)	LIDI R	E) DIE	29d. Date signed (Mor 07/28/2 2 MD 2/D	14
	12		DESHSHARMI			DD KU #	1-6 71	~ 111°C	, mo dio	//
9	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 1	32. Jegistrar's Signat	K A	eile				

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28, 2006 **Physician** 00:45 Alfred D. Levitas July /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex **Funeral** 152M 2□ F Yrs. March 27, 1920 059-03-9245 86 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 27 is marked other than "neturel", or iteme 23a or 28a-f show treumatic event, the Modical Examinar mast be notified at 1 ☐ Yes 2 ☑ No Directo Montgomery Rockville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? parmit. Pagas 1 and 2 should be filed within 72 hours after death with ti Department of Health and Mental Hygiane. Important: If Item 27 ie marked other than "netures", or iteme 23a or 29 any injury or other treumatic event, the Mendane. United States 20852 #505W 6121 Montrose Road, Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 No Specify: Specify: White 3 N Widowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Professor College 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Samuel Levitas Fannie Meyerson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4552 N. Chelsea Lane, Bethesda, Maryland, 20814 Stephen Levitas/ Son 20b. Place of Disposition (Name of 20a Method of Disposition July 30, 20c. Location - City or Town, State King David Memorial Gardens 1

Burial 2

Cremation 3

Removal from State 2006 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, Virgina 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave Bethesda, Maryland, 20814 21. Signature of Funeral Service Licensee M01473 Approximate Interval Between Onset and Death 23a. Part1. Enter the dispesse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SOOSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Metostatra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attanding physician and for usa as the burial-transit The law requires that the death cartificate be executed resulting in death) Last Due to (or as a consequence of). Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown ate has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hospital or Attending Physician: diractor, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No After thi funaral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending daath. ctor: Af y tha fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined within 24 hours aftar dai To the Funeral Directo complataly fillad in by th 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JULY 28, 2006 64415 Lind X MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nimesh S. Shah, MD 9901 Medical Center Drive, Rockville, Maryland, 20850 32. Signature 31. Date filed (Month, Dav. Year) State AUG 0 1 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend I tem 1 per doc 2008 8-0-06 vt. lealth and Mental Hygiene amend item 20b per Reg. No.2 0 0 6 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Michael Manfreo Loe MICHAEL MANFRED LOE Year Month **Physician** 1240 7006 YIUT /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Horrland Medical Country Baltimore NIA University of If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1⊠M 2□F 471-58-9302 57 September 20, 1948 Minnesota Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iteme 23a or 28a-f show eny injury or other treumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12701 Dean Road 20906 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S.
Amed Forces?
1 ⊠Yes 2 □ No 1969—
If Yes. Give 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Yes, Give rear or Dates: Specify: White à 1996 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Physician Assistant Health Care lichael Loe 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Manfred G. Loe, Sr. Bernice Matula 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12701 Dean Road, Silver Spring, Maryland 20906 Brenda J. Loe / Wife 20b. Place of Disposition (Name of OCTOBER 20c. Location - City or Town, State 20a. Method of Disposition Arlington National 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, Virginia 2006 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Dicenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myelopenous **Physician** /Medical Due to (or as a consequence of) Examiner Crestrointes tino Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien end for use as the burlal-trensit The law requires that the death certificate be executed Reard Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Eucephal Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by chelosion, 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? toperio 24a. Was an certificate has b irector, page 2 s autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☑Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this rector: After this by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 Natural 5 Pending 1 Tyes 2 No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Direct Direct in by t 4 | Homicide ō To the Hospital o wi hin 24 hours aft To the Funerel Di Contifying Physician: To the best of vily knowledge, death conumed at the time, date and place, and due to the mainse(s) and manner as stated 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

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32. Rigistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CIVERNE

1 2006

31. Date filed (Month, Day, Year)

AUG 0

19668

M. BROWN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Dianne 3:21 A M Lamont July 26. 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4711 Alcon Drive Prince George's Camp Springs 8. Date of Birth 9. Birthplace (State or Foreign Springfield, MA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2♥F 74 Yrs. 011 26 0884 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a, State 10b. County r then "naturel", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Camp Springs Maryland Prince George Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20748 Drive 4711 Alcon United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. The process important: if item 27 is marked other then "naturel", or Items 23a appl. Injury or other treumatic event, the Medical Exemples 2008. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes **XX**No Specify: ₽ ₩Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Education 1 12 Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Doris Whitney Donald Ross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4711 Alcon Drive, Camp Springs, MD 20748 Valerie Lamont (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) July 31, 2006 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Longmeadow, Mass. Longmeadow Cemetery 4 □Donation 5 □Other (Specify) 21. Signatura of Furgeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735 23a. Paryl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Belween Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to intro-diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) attending physicien and for use as the burial-transit Examir Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 4 No page 2 s autopsy certificate 1 Yes 2 12 No After this certification Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 4 Residence 6 Other (Specify) P 1 Yes 2 No 28c. Injury al Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours efter death.

To the Funeral Director: Al
completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated ş 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 06 D052023 morra 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 122 Defense Highway Suite 200 Annapolis, Maryland Maria Romero M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 1 2006

32. Segistrar's Signature

cian	1.	Decedent's Name (First, Middle, Last)				Date of Death Month	30 2006	3. Time of Death 11:46 A M
lical		FLORENCE		LEVINSON 4b. City, Town, or Loca		JLY 3	4c. County of Dea	
iner	4a	Facility Name (If not institution, give street and nun RUXTON PIKESVILLE NURS		PIKESVIL			BALTIMOR	
il r	5.	Social Security Number 547 – 36 – 5948 6. Sex 1 M 2 X F	7. Age (In yrs. last birtho	(ay) If Under 1 Year If Under 1 Year If Under 1 Year	Inder 24 Hrs. 8 1	Date of Birth	1912 9. Bi	rthplace (State or Foreign Country) MD
	_	a, State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
ō		MD BALTIMORE	BAL	TIMORE				1 ☐ Yes 2 No
I Director	10	13 COBBLESTONE COURT,	APT. 2A	2:	215 1208		og. Citizen of What C	USA
by Funeral	2		edent Ever in U.S. rces? 2 XX No /e ates:	^	pecify:		Black, Wh	WHITE
Completed		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0.12) College (1-40(5+)	ecedent's Usual Occupatior Give kind of work done durin ife. DO NOT use retired) IEMAKER	n ng most of working		OWN HOME	sundustry
		7. Father's Name (First, Middle, Last)	1101		Mother's Name (F	irst, Middle, N	Maiden Sumame)	
To Be	í	HYMAN		INSON	EMMA			KEMPER
		9a. Informant's Name/Relationship (Type, Print) ROBERT LEVINSON / BROTH	IER 320	Mailing Address (Street and) 9 SZOLD DRIV	E - BALTI	MORE,	MD 21215	21208
	2	0a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	cemetery	Disposition (Name of crematory or other place) YOUNG MEN CE		2006	WOODLAWN,	MD
once.	1	21. Signature of Funeral Service Licensee ACATA 23. Part1. Enter the disease, or complications that	h	22. Name and Address of 8900 REISTE	RSTOWN RC)AD - F	PIKESVILLE	5., INC. , MD 21208
an al er	ımıner	Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(or as a consequence of	f): f):	4 //	HLUK		
1	Physician/Med	23b. Was decedent pregnant	utcome of pregnancy birth 2 Fetal death gnant at time of death nown	3 Ectopic pregnancy 5 Other (specify)			23d. Date of Month	delivery Day Year
	۵	Part Other significant conditions contributing to DEMENTA	death but not resulting in	the underlying cause given	in Part I.			e to the cause of death
	ompleted					24a. Was autop perio 1 Yes	rmed? / prior deat	e autopsy findings availate to completion of cause h? Yes No
3	BeC	25. Was case referred to medical examiner?			26. Place of Death (
- (- Desire		Inpatient 2 ER/Ou	tpatient 3 DOA Other:	Nursing Home		dence 6 Other (Specify)
	ဥ	OZ Mannor of Dogth 28a Dat		njury Work?				
	$\vdash \psi$	Natural 5 Pending			s 2 No			
	$\vdash \psi$	Natural 5 Pending Mid	ce of Injury - At home, fallding, etc. (Specify)	M 1 ☐ Ye	28	City or Tov	wn, State)	or Rural Route Number,
	Certification: T	Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medical Examiner: On the	ce of Injury - At home, falding, etc. (Specify)	M 1 ☐ Ye	date and place, as	City or Tov	wn, State) cause(s) and manne date and place, and	er as stated. due to the cause(s)
טופופון וווופט ווו טץ נוופ ימויפומו מויפנטי. ד	$\vdash \psi$	Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only ne) 29b. Signature and title of certifier	ce of Injury - At home, falding, etc. (Specify) the best of my knowledge basis of examination an anner stated.	M 1 ☐ Ye	, date and place, ar nion, death occurred	City or Tov	wn, State)	er as stated. due to the cause(s)

			1 - For Amend itm#10b	,10c, State of	Maryland / D. F, perfil, 685	epartment of Sertificate of	Health a f Death	and Me		ene . No.2 0 0	6 24027	
* .	Physici	an	1. Decedent's Name (First, Middle				2. Date of Death Month	Day Ye	3. Time of Death 2:45 p M			
	/Medic Examir		4a. Facility Name (If not institution		ry E. Lenzi	4b. City, Town	or Location of	of Death	July	/ 16, 2006 4c. County of E		
-	Examili	lei		aint Joseph Me		,		_	wson	,	Baltimore	
- 0°	Funeral		5. Social Security Number		. Age (In yrs. last birth				8. Date of Birth (Month, Day, Y	9.	Birthplace (State or Foreign	
	Director		160-05-7527	1 □ M 2 2 3 4 F	89 Y	rs. Months Day	s Hours	Min.			Country)	
P	>		Usual Residence of Decedent 10a. State 10b. County		100 City Taylor				February 3	1917	Pennsylvania	
anyla	Department of Health and Mental Hygiene. importent: or items 23a or 28a-f show importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be multified at once.	'n		Delaware	10c. City, Town	ш	ton Heig	_			10d. tnside City Limits 1 ☐ Yes 2 No	
he N		ect	Pennsylvania 10e. Street and Number 311	S. Penn Ave			leven ∀al 19018	lley's	40-	Oldina - 4 Jan		
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eath	18 23	eral	882 Cougar Pointe		ent Ever in U.S.	13. Was Decedent of			cify Ves or No.	14 Page 4	U,S.A.	
fer d	F F	E	1 ☐ Never Married 2 ☐ Marri	Armed Ford	es?	If Yes, specify Cu	ban, Mexican	n, Puerto P	Rican, etc.)		Vhite, etc.	
036	0,18	þ	3 ₩idowed 4 Divorced	If Yes, Give Year or Dat	•	1 ☐ Yes 2 2 N	o Specify:			Specify:	White	
21215-0036 3d within 72 hours af	cal	Completed	15. Decedent		16a. E	ecedent's Usual Occ	upation	e of workin	16	b. Kind of Busine	ess/Industry	
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24 M	vgien t, the	S	12			Produ	ction Sup					
	d off	Be	17. Father's Name (First, Middle, I	Last)			18. Mothe	er's Name	(First, Middle, Ma	iden Sumame)		
	Men Marke Martic	ျှ		seph Gabay						y unknown		
Maryland d 2 should be file	h and 7 ts m rraum		19a. Informant's Name/Relationsh			Mailing Address (Stre				-		
6, –	Healt em 2 ther		Mr. Anthony J. L. 20a. Method of Disposition	enzi	Son	882 Cougar Disposition (Name of	Pointe C		even Valley's	s, Pennsylva c. Location - City		
altimore,	ages nt of h t: If ite		1 ⊠ Burial 2 ☐ Cremation	3 Removal from Si		crematory or other p	lace)					
	orteni injury		4 Donation 5 Other (Sp	11		SS. Peter & P 22. Name and Add	20.22		21/2006	Bro	oomall, PA	
8 §	Depa impo sny ir		XIII VIII.	10.1	0000535	Slac	k Funeral	I Home.	, P.A.			
	7 1.6		3a. Part 1. Enter the disease, or shock, or heart failure. List	complications that car	used the death. Do no	3871	Old Colu	umbia F	Pike Ellicott (City, MD 21	Approximate	
D.			shock, or heart failure. List	only one cause on ea	ch line.						Interval Between Onset and Death	
*-	nysician Medical		disease or condition resulting in death)		MYOCARDIAL r as a consequence of)NN				TWO DAYS	
E	kaminer		2 10 1			,,						
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cuted	nd transi	Examiner										
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8760, cate be ex	hysic the b	dicai	d									
eriffic 6	ding p	Med	IF FEMALE:	222 14								
Box leath cert	attenc for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	ome of pregnancy th 2 ☐ Fetal death	3 Ectopic pregnan	су			23d. Date of Month	delivery Day Year	
o 🖁	the	ysic	1 □ Yes 2 No 9 □ Unknown	9☐ Unknov	nt at time of death vn	5 Cother (specify)						
J E	ed by the attending I detached for use as	h h	Part II. Other significant condition	ns contributing to dea	th but not resulting in t	he underlying cause o	nderlying cause given in Part I. 23e. Did tobacco use contril				e to the cause of death?	
dS wires	been signe should be	d by				, ,			1 ☐ Yes	2 No 3	Probably 4 Unknown	
S P P	shou	Completed							24a. Was an	24h Word	autoocy findings available	
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<u>a</u>	certificate rector, pag	e C	25. Was case referred to medical				OG Filoso	of Dooth	1 ☐ Yes 2. (Check only one)	No 10	Yes 2 No	
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0 4	er this ieral di	Ë	27. Manner of Death	28a. Date of	Injury 28b. Tin	ne of 28c, Inj			8d. Describe how		эрвспу	
VISION Attending	ath. ir: After se funer	atlo	1 Natural 5 Pending 2 Accident investig	ation	Day Year) Inju		∃Yes 2 🗆 t	No				
Division of Vital Records, tor Attending Physicien: The law requires t	after death Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 200. Flace 0	f Injury - At home, farm	, street, factory, office	9	28	8f. Location (Stree City or Town, S		r Rural Route Number,	
itel o	rrs aft rel Di led in											
dsop	4 hou Fune ely fil	edicai	(Check only 2 Medical I	g Physician: To the b Examiner: On the bas	est of my knowledge, is of examination and/	death occurred at the	time, date and	d place, ar	nd due to the caus	e(s) and manner	r as stated.	
DI To the Hospitel or	within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Med	onej	and manne	r stated.				т т			
5	T CO		29b. Signature and title of certifier	0 / 11.		29C. LICHI	nse number D3	30042	29d.	Date signed (M	Ola, Day, Year)	
	. 0		1// 2	4011	dei					1128	104	
	M		30. Name and address of person v Mark G. Midei, M.D				1					
: Star	Sta	te	31. Date filed (Month, Day, Year)		istrar's Signature		f					
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Registrar

DHMH 17 Rev 1/2001

Mitchell, Marion

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ind. 11cms 26,28a,e, f per doc 8858 8-1-06 vt. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No.-2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Messial **Physician** Bobb; e 100 July 24 2006 7:00 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Neme (If not institution, give street and number) Examiner 125 E. Timonium Rd. Timonium Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 ☐ M 2 ☐ F Yrs. March 8 1944 Director Kentucky 212-42-5200 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show iiit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Heath and Mantal Hygiene. crtant: If Item 27 ie marked other than "natural", or Iteme 23a or 28a-f show mayery or other traumatic event, the Mudical Examinar must be notified at 1 ☐Yes 2 No MD **Baltimore Timonium** Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 125 E. Timonium Rd. USA 21093 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Director of Training Computer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edna Trent Lucian Burdett Snodgrass 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ellen Davies Hoadley/companion 125 E. Timonium Rd., Timonium MD 21093 Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 □ Removal from State Metro Crematory 7/29/06 Catonsville, MD 5 Opper (Specify) Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 ervice Licensee Once Dep Lemmon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) in Anna Dion Physician None MYUCAZAM /Medical Due to (or as a consequence of) Examiner HUCCZUPIA EMY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed HY (ER TEN) LE Due to (or as a consequence of) anding physician a use as the burial-Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day detached for 4☐Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed certificate 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient® 2 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1- Natural 5 Pending NIA 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident 21100 within 24 hours efter deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc., (Specify) þ 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical | Security in a restriction in the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) F e Albert 29b. Signature and title of certifiq 29c. License number 29d. Date signed (Month, Day, Year) Dicerolano, no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PADONIT 35 E - Manie 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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2006

State of Maryland / Department of Health and Mental Hygiene U U 5 State
Registrar Certificate of Death 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) ^{Day} 2006 Physician 27. A^{M} July 5:30 Mulford R. Jack /Medical 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 10420 Glen Road Potomac Montgomery 8. Date of Birth
(Month, Day, Year)
Aug. 10, 1 Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F Yrs 76 Ohio Director 279-24-0562 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d Inside City Limits 10a. State 10b. County ir then "natural", or itema 23a or 28e-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Maryland Montgomery Potomac Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10420 Glen Road 20854 United States death Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ∰ Yes 2 □ No Korean If Yes, Give Year or Dates: Conflic 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Conflict White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Human Resources Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any lioury or other traumatic event pose. James Mulford Lois Dakin 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kay Frances Mulford/Wife 10420 Glen Road, Potomac, Maryland 20854 20b. Place of Disposition (Name of comelery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State July 30, Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature & Funeral Service Licers of M00803Bethesda, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Variable Extrathoracic Airway Obstruction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use es the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Parkinsons Disease 1 Yes 2 No 3 Probably 4 Unknown been si 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate 2 □ No 1 TYes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No M investigation Director: / 2 Accident 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 13x1 D26571 July 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10215 Fernwood Road, Bethesda, Maryland 20814 Irving Mizus, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Physicia dical Exami	ın/	Registrar 1. Decedent's Name (First, Mid		——— KENN	NETH	MIL					Date of De Month July 28, 2	Day	Year		3. Time of Death 2129 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Sinai Hospital 4c. County of Death Baltimore								f Death	N/A				
Funeral Director		5. Social Security Number 212-56-6082	6. Sex	7. Ag	e (In yrs Ia	st birthday)		nder 1 Year nths Days	If Under Hours	24Hrs. Min.	Tourism 1				
any		Usual Residence of Decedent 10a. State 10b. County	1 /			Town or Loc	ation				· ·			1	10d Inside City Limits
oith the Maryland 5 23a or 28a-f show a contilied at once.	Director	MD N	I/A			BAL	TIMO	RE Zip Code				10g. Cit	izen of Wh	at Coun	1 X Yes 2 No
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15-0036 filed within 72 hours after death with the Mary-land it Hygiene ed other than "natural", or items 23a or 28a-f slu. i, the Medical Examiner must be notified at once	by Funeral		1 X Yes Divorced If Yes, Give Ye or Dates:	2 ear	No	1	Yes	2 X No	specify:			Lion	Specify:		WHITE
5-0036 lled within 72 hours after Hygiene fother than "natural", the Medical Examiner	Completed	15. Decedent's Education (Sp Elementary/Secondary (0-12		1-4 or		during	most of	ual Occupation working life. I	DO NOT (Kind of Bus		ŕ
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ges I and 2 should be fit to Health and Mental I: If liem 27 is marked other traumatic event,	TOE	19a. Informant's Name/Relation						ess (Street DBOURI					-		
Baltimore, Nemit Pages I and Department of Health Important: If item injury or other trau		20a. Method of Disposition 1 X Burial 2 Cremati 4 Donation 5 Other		from St	ate	Place of Disponentations of Place of Disponentations of Place of Disponentations of Place of Disponentations	other pla	ice)			Date 80/200		Location -	-	Fown, State E, MD
Baltin permit. I Departm Importa		21. Signature of Funeral Service			-1	22.		nd Address	-						S., INC. E, MD 21208
Physician /Medical Examiner		23a. Part I. Enter the disease, failure. List only one caus Immediate Cause (Final disease)	se on each line. se a Neck and				r the mo	de of dying, s	such as ca	rdiac or r	espiratory a	rrest, sh	ock, or hea	rt	Approximate Interval Between Onset and Death
	J.	or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as b. Due to (or as												
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0, be executed sician and ourial - transit	=	UNPENDED	dAMENDED												
Division of Vital Records, P.O. Box 68760, within 24 hours after death or fitting Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition.	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	1 Live	birth nant at	me of preg	2 I	Fetal dea	-	Ectopic	pregnand	су	23	3d. Date of Month	,	ay Y ear
P.O. Fres that the signed by the be detached	þ	Part II. Other significant cond	ditions contributing	to deat	h but not re	esulting in the	e underl	ying cause gi	ven in Par	rt I.		-			he cause of death? ably 4 Unknown
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Division To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 Homicide	etermined (Specif	/) Lo	cal Stre					6	or Town, 612 Bonr	State) nie Rid	lge Drive	, Broc	ral Route Number, City oklynville, MD
To the Hospital within 24 hours To the Funeral completely filled	Medical	one) 2 Medical E	Physician: To the b xaminer: On the basi and manner	s of exa	ny knowled mination a	ge, death occ nd/or investion	curred at gation, ir	the time, dai my opinion, 29c License	death occ	ce, and d curred at t	ue to the ca	e and pl	lace, and di	ue to the	e cause(s)
4	2	29b. Signature and title of cert	M. Ot	4				O.C.N					y 29, 200		th, Day, Year)
10			eputy Chief Med	lical E	xamine	r 111 P	enn S	treet, Balt	imore, N	MD 212	:01				
Regis		31 Date filed (Month, Day, Yea	1 2006	gistra	ar's Signatu	K A	nasti	ر'							
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Physici	an/	Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year Live 11 2006 2359 hrs				
Medical Exam		Olusheyi Ogboye 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or	July 11, 2000				
		7400 MLK Blvd Seat Pleasa	Prince George's				
Funeral		5. Social Security Number unk 6. Sex 7. Age (in yrs. last birthday) If Under 1 Year Months Days	Foreign				
Director		1 X M 2 F 50 Yrs.	Sept 8, 1955 Country) Nigeria				
any		Usual Residence of Decedent 10a. State	10d Inside City Limits				
ind show ice.	٦	MD Prince George's Seat Pleasant	1 Yes 2 XNo				
th the Maryland 23a or 28a-f show any notified at once.	Director	10e. Street and Number 10f. Zip Code	unk 10g. Citizen of What Country?				
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eath w items ust be	Funeral	1 X Never Married 2 Married 1 Yes 2 X No	n, Mexican, Puerto Rican, etc.) White, etc.				
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136 htn 72 e than '	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) unk couries	r delivery				
5-00 led wit Hygien other			18 Mother's Name (First, Middle, Maiden Surname) unk				
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ore, MD 21215-0036 ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Manell Hygiers, filem 27 is marked other than "natural", or items 23a or 28a-f she ther tranmatite veent, the Medical Examiner must be notified at once	۲		nue Fairmont Heights, MD 20743				
imore, MI Pages 1 and 2 s nent of Health a ant: If item 27		20a. Method of Disposition 20b. Place of Disposition (Name of cer					
MOP Pages nent of		1 Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 X Other Specify: in state					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death will be prement of Health and Mental Hygiene. Important I fitem 27 is marked other than "natural", or items injury or other tranmatic event, the Medical Examiner must be		21 Sanature of Fundral Service Licensee	tomy Board 655 W. Baltimore Street, MD 21201				
Physician		23a. Part I. Enter the dispase, or complications that caused the death. Do not enter the mode of dying,	such as cardiac or respiratory arrest, shock, or heart Approximate Interval				
/Medica		fature List only one cause on each line. Immediate Cause (Final disease a Cardiac Arrhythmia	Between Onset and Death				
Examine		or condition resulting in death) Due to (or as a consequence of):					
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
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1760, ficate be executed g physician and s the burial - transit	ו/Medical	Xunpended item#23a,27,28a-f,perME,g85	59,9/15/06 TT				
	//Me	IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	23d Date of delivery				
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. Bo he deal y the all	Physicia	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause (given in Part I. 23e. Did tobacco use contribute to the cause of death?				
of Vital Records, P.O. Box 68: Jing Physician: The law requires that the death certificate has been signed by the attending fineral director, name 2, should be detached for use as	þ		1 Yes 2 No 3 Probably 4 V Unknown				
rds, require been si	Completed		24a, Was an 24b, Were autopsy findings available prior to completion of cause of				
ecol he law tte has	l dinc		performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No				
al R lan: T certifica ector, pa	Be C	25. Was case referred to medical 26. Place	e of Death (Check only one)				
Division of Vital Records, tal or Attending Physician: The law requirers after death al Director: After this certificate has been sized in by the fineral director page 2 should be led in by the fineral director page 2 should be	10	Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA	Other Nursing Home 5 Residence 6 Other: Scene ary at Work? 28d. Describe how injury occurred				
on of nding of th	ion:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 3 Pending Fnd 7/11/2006 Fnd 11:50 pm	Yes 2 No unk				
/iSiC r Atter ter dea irector	ficat	Accident Investigation Suicide	A CHAC				
Div pital o burs aft eral D	Certification:	Homicide Specify Found in a parking lot	building, etc 28f. Location (Street and Number or Rural Route Number City or Town State) 7400 Martin Luther King Blvd. Seat Pleasant, MD				
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certivithin 24 hours after death To the Funeral Director. After this certificate has been signed by the attendin			late and place, and due to the cause(s) and manner as started. n. death occurred at the time, date and place, and due to the cause(s)				
To the within To the	Medical	and manner stated. 29b. Signature and title of certifier 29c. Licens					
	-	Mha Brasell III o.c.	M.E. July 12, 2006				
	30. Name and address of person who completed cause of death (Item 23a)						
		E RA ELANT	Baltimore, MD 21201				
	State	e 31. Date filed (Month, Day, Year) 2006 37 Registrar's Significe					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July ^{Day} 2006 V. 01son Physician Janet 29, 7:50 P M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number, Examiner Rockville Montgomery Collingswood Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2ĂF 103-36-4176 Yrs. August 11, 1944 **Director** New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "naturel", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Maryland Rockv111e Montgomery Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20850 United States 299 Hurley Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☒ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 4 Hospital Registered Nurse permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies importent: If item 27 is marked other th any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dorothy Virginia Davis Rudolph Emil Schallow, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Battery Bend Court, Montgomery Village, Maryland 20886 Eric K. Olson / Son 20b. Place of Disposition (Name of July 31, 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland Montgomery Crematorium, Inc 1 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. Mydellal Says M01305 1300 West Montgomery Avenue, kockville, Maryland 20850-2805 23a. Part i. Firer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ischemic Heart Disease /Medical Due to (or as a consequence of) Examiner Multi Infarct Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Completed by Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 6 4⊡Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 💢 No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sign be 1 ☐ Yes 2 No. 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 2 No 1 Yes Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) director Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. M investigation 2 Accident after death Director: the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide within 24 hours a To the Funerei I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 31, 2006 H0051280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) b Anushiravan Dadgar, D.O. 9715 Medical Center Drive, Ste 201, Rockville, MD 20850 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 1 2006 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of	Marylan	•	artmen					Reg. No. 2	106	24034
	Physici		1. Decedent's Name (First, Middle, Last) William Frederick	Peter							2. Date of D	eath Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s Franklin Square Hos	spital			4b. City,	(05	Location of	LE	D. Davis of B	4c. Cour Ba	ty of Death	
	Funeral Director		377 40 0703	M 2□F	7. Age (In yrs. 1	Yrs.	Months	Days	Hours	Min.	Month, D	irth ay, Year) 19,1931	Cour	place (State or Foreign htry) Yland
	aryland show	ř	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore	3	10c. City	y, Town or Lo							1	10d. Inside City Limits 1 ☐ Yes 2X No
	ith the M or 28e-f	Funeral Director	10e. Street and Number			TCLLY	10f. Zip					10g. Citizen o		
	death w	neral	8623 Winding Way 11. Marital Status 1	2. Was Dece Armed For	dent Ever in U.	S. 13.				in? (Spe	cify Yes or N Rican, etc.)	US 0- 14. R	ace - Americ lack, White,	
Liams 15-0036	ours after al', or its Exemine	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 월 Divorced	1 X Yes		_	1 ☐ Yes		Specify:		noun, cici,		ity: Whi	
11/C	within 72 hours after death with the Maryland ene. Han 'natural', or items 23a or 28e-f show the Mudical Examinar must be notified.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)						ation during most	nost of working 16b. Kind of Business/Industry Air National Guard				
$RS_1 \cup U_1 \cup U_1 \cup M$ Maryland 21215-0036	d be filed wintal Hygien ed other the	Be	12 17. Father's Name (First, Middle, Last) William Michael Pet	ter		Se	rvice	man			(First, Middle Ann Fu	e, Maiden Sum		
25, Mary	2 should and Men is marke	To.	19a. Informant's Name/Relationship (Typ.			(_					ber, City or Tow ryland		
PELE 1			Michael F. Peter (\$20a. Method of Disposition 1 Burial 2 Scremation 3 CR 4 Donation 5 Other (Specify)		State Bay	Mace of Disponentery, creative (View (osition (Nan matory or o	ne of ther plac	e) c		ate	20c. Location	n - City or To	
Baltin	permit. P Depertme importan any injury		21. Signature of Funeral Service License	e Bui	rko.	22 B	2. Name an Bruzdz	d Addres	ss of Facility	eral	Home	P.A.	farvla	nd 21221
W. 0928		ilcal Examiner	23a. Fart 1. Enter the disease, or complications, or heart failure. List only on disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underfying Cause (Disease or injury that inditated events resulting in death) Last	Due to (uence of):		e of dyin	g, such as c	cardiac of	respiratory	arrest,		Approximate Interval Between Onset and Death
Division of Vital Becords. P.O. Box 68	Physician: The law requires that the death certifical this certificate hes been signed by the attending phy all director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live b	come of pregna irth 2 ∐ Feta ant at time of d own	I déath 3	⊒Ectopic pr ⊒ Other (sp				SUA A		Date of deliver	ery Day Year
d.	law requires that es been signed b		Part II. Other significant conditions con	tributing to de	eath but not res	ulting in the u	underlying c	ause giv	en in Part I.		1	tobacco use co Yes 2 □ No		the cause of death?
Reco	sician: The law requirections been rector, page 2 should	Completed									per	s an 24l opsy formed? 2 No	o. Were auto prior to co death? 1 \(\text{Yes} \)	opsy findings available ompletion of cause of
Vita	Physician: The l this certificate he al director, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	npatient 2 🖪	ER/Outpatie	00 00	Oth	or		(Check only		Mh (G	4.1
on of	Attending Physic death.	atlon: To	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date o		28b. Time o Injury		28c. Injur Wor		2		sidence 6 C		<u>y</u>)
Divis	of or Attendated Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place buildii	of Injury - At h	ome, larm, st	reet, lactor	y, office		2		(Street and Nul own, State)	nber or Rur	al Route Number,
	To the Hospitel or Attending Is within 24 hours efter death. To the Funeral Director: After completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Physical Check only one)	ner: On the ba	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	th occurred nvestigation	at the tir	ne, date and pinion, deat	d place, a	and due to the	e cause(s) and e, date and plac	manner as s e, and due t	stated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	Luni	LAL	/ ~~~	290	c. Licens	e number	762		29d. Date sig		-
	441		30. Name and address of person who co	mpleted caus	e of death (Iter	n 23a) (Type	, Print)	0	9- 00	. Ac	Ba.	+more,	M	21727
×	Sta Regist		31. Date filed (Month, Day, Year)		egistrar's Signa	A A	male)	-	Muke	CAK	· 1 17151	THINDRE		JON

Dogglas	A	INTHONY Pulley	oliblo lak						
UNK UNK		Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene							
OTTIC OTTIC		1- For State Certificate of Death	Reg No.	2006 2403					
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	Date of Death Month Day	3. Time of Death					
Medical Examin	ıer	Douglas Anthony Pulky	July 27, 2006	0250 nrs					
Port of the second		4a. Facility Name (if not institution, give street and number) 4b. City, Town, C University Hospital Baltimore	r Location of Death 4c.	County of Death					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	ar If Under 24Hrs. 8. Date of Birth (MM/D	DD/YYYY) 9. Birthplace (State or					
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v any	1	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 Yes 2 No					
land f shov	ğ	Md N/A Baltimore	140- 08-	en of What Country?					
Mary r 28a-	Director	10e. Street and Number 10f. Zip Code							
r death with the Maryland or items 23a or 28a-f show must be notified at once.	a D		216 ispanic Origin? (Specify Yes or No-	USA 14 Race - American Indian, Black,					
eath w	Funeral		in, Mexican, Puerto Rican, etc.)	White, etc.					
after d	by Fi	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Specify: Black					
hours	edt	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occup during most of working life		ind of Business/Industry					
36 in 72 l	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Construct	ion Worker	Private					
5-0036 iled within 77 Hygiene I other than	E	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Maiden S						
and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Be	Anthony Pulley	Barbara Di	20N					
21 hould I nd Mer is man	2	19a. Informant's Name/Relationship (Type, Print) Hund 19b. Mailing Address (Stre	et and Number or Rural Route Number, Cit	y or Town, State, Zip Code)					
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		4 Donation 5 Other Specify 21. Signature of Emeral Service Ligensee 22. Name and Addre	ss of Facilit Chartman	tarcis Funeral Home					
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Box 68760, e death certificate be the attending physic ed for use as the bur	ciar	past 12 months? 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 Other (Specify)	Lotopio programoy	mona, bay					
Boy e death the att	hysi	1 Yes 2 No 9 Unknown 9 Unknown		(2) () () () () () () () () ()					
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cord law rechas be has be 2 shou	Completed		autopsy perform <u>ed</u> ?	prior to completion of cause of death?					
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of V g Phy frer th	.: To	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Ir	jury at Work? 28d. Describe how inju						
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Divisior Divisior Division Septial or Attend hours after death uneral Director:	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	or Town, State)	nd Number or Rural Route Number, City					
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= 4 2 5	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opini	date and place, and due to the cause(s) and on, death occurred at the time, date and pla	d manner as started. ice, and due to the cause(s)					
To the within To the comple	Med	and manner stated. 29b. Signature and title of certifier 29c. Lice	nse number 29d [Date signed (Month, Day, Year)					
	_		C.M.E. July	27, 2006					
7		30. Name and address of person who completed cause of death (Item 23a)							
J		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore	, MD 21201						
	tate								
Regis	цеП	AUG 11 1 / 1000 RAPERSON	-						

			St State Amend item#1,perMD	ate of Maryland / Depa ,g858,8/1/2006 TT <i>Cer</i>	artment of Health and Natificate of Death	Mental Hygier	ZUUb	24036				
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death						
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	Examin	er	4a. Facility Name (If not institution, give street Tohns Hopkins Ho		4b. City, Town, or Location of Death Baltmore		4c. County of Death					
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign				
	Director	2	25 76 0815 10M	22(F 54 Yrs.	Months Days Hours Min.	July 29, 19	951 100	w York				
	pu .		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits				
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	28a-	Director	10e. Street and Number	13 11 11 11	10f. Zip Code	10g. (Citizen of What Cou	intry?				
	ier death with the Marylan Iteme 23s or 28s-f show instrinust be notified at	a D	6203 LAKEMON	4	2/228		USA					
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5	les 1 ar of Hea If item or othe		20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place)	Date 201	Location - City or T	PA 23847 own, State				
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altimore	permit. Pag Department Important: any injury c		21. Signature of Funeral Service Licental		. Name and Address of Facility		mr11 tu	werd Home-				
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		0	233. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fine to cause (Fine).									
	Physician		disease or condition resulting in death)	Restrictive cardi	anyopathy		·	20+ years				
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S,	es tha igned I be det	by P	Part II. Other significant conditions contribu	ting to death but not resulting in the ur			o use contribute to	the cause of death?				
of Vital Records,	w requir been si should I	ted	Kenal tallure, no	gnt uppor lobe	cantum ieston	1 Yes	2No 3∏Pro	bably 4 Unknown				
ec	e law r has be 3e 2 sh	Completed	splenic and portal	vein intarts/	hombons	24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of				
ᇤ			er was see			performed?		2 No				
ΖÏ	2 8 6	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospi	tal: 1 npatient 2 ER/Outpatien	104	th (Check only one)	A (7)011 / (2)	,				
	g Phys er this eral di	H- 1	27. Manner of Death 28	Ba. Dite of Injury 28b. Time of	4 Nursing H	ome 5 Residence 28d. Describe how in		ry)				
Ö	Attending I or death. ector: After by the funer	atio	1 Anatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	M 1 Yes 2 No							
Division	or Atte efter de Directo in by th	Certification:	3 Suicide 6 Could not be determined	Be. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta		al Route Number,				
۵	ospital or A hours efter uneral Dire ly filled in by											
	24 ho Fune stely (edicai	(Check only 2 Medical Examiner:	 To the best of my knowledge, death On the basis of examination and/or invalid manner stated. 	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as s and place, and due t	stated. o the cause(s)				
	To the Hospital or Attend within 24 hours efter death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier		29c. License number	29d. E	Date signed (Month,	Day, Year)				
			SAMUL Mer	hicine Housestaff	RES-000	Jul	122,2	006				
-	Ī		30. Name and address of person who comple	eted cause of death (Item 23a) (Type,	Print)		1	-				
				Hopkins Hospital 6	000 N. Wolfe St. Balt	mae, MD	21287					
	Sta Registi		31. Date filed (Month, Day, Year) ALIC 0 1 200	32. Registrar's Signature	soul.							

			For State Registrar		State of	f Marylan		artment rtificate		ealth and Death	Mental Hy	/giene/ Reg. No.	2006	24037
	Physicia		1. Decedent's Nam Bahy	Boy Pat	-						2. Date of D Month	eath Day	200 (-	3. Time of Death 3:50 PM
	/Medic Examin				give street and nun	nber)		4b. City, T	own, or	Location of Deat	h	4c. C	ounty of Death	
	LAGITITI	٠. ا	Frankli	n Sai	vare Ho	os Dital		R.	ose	edale		T	Balti	more
	Funeral		5. Social Security		S. Sex	7. Age (In yrs.		If Under 1 Months	Year Days	If Under 24 Hrs Hours Min.	(Month, D	ay, Year)	9. Birth	place (State or Foreign ntry)
19	Director		none		1 ∑ M 2□F		Yrs.			Hours Min. 2 5	July 2	22, 20	06 Mar	yland
	and		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	Manyl f sho	ō	Md	Baltir	nore		Roseda	1e						1 Yes 2 No
	r 28e-f show	rect	10e. Street and Nu	1				10f. Zip (Code			10g. Citize	en of What Cou	
	h with	0	5050 Spi	ringhous	e Circle					21237			USA	
	deat	Funeral Director	11. Marital Status		12. Was Dece Armed For	dent Ever in U	.S. 13.	Was Decede	ent of His	spanic Origin? (S n, Mexican, Puer	Specify Yes or N	0- 14	4. Race - Ameri Black, White,	
036	72 hours after death with the Maryland natural', or Items 23a or 28e-f show dical Examirer must be notified at	þ	1 🛣 Never Man 3 □ Widowed	ried 2 Marrie		2 No ates:		1 Tyes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,		Specify: Whi	
- 21215-0036	n 72 hours "natural", oldal Ex	Completed	(Spe	15. Decedent's cify only highest	Education grade completed)		(Give	dent's Usual	done d	during most of wo	rking	16b. Kind	d of Business/Ir	ndustry
121	within sne. then	Id III	Elementary/Sec	ondary (0-12)	College (1	-4or 5+)		DO NOT use	e retirea,)				
75	filed v Hygie other t	e Co	none 17. Father's Name	(First Middle L	none		none			18. Mother's Na		none e. Maiden S	iumame)	
ang	d be f	To Be		esh Pate							shpa Pa		,	
A I	shoul nd Me mark	ř	19a. Informant's N				19b. Maili	ng Address	(Street a	and Number or R			Town, State, Zij	p Code)
Q ¥	nd 2 alth a 27 is r trai		Frankl:	in Squar	e Hospita	a1	9000	Frank	:lin	Square	Drive R	oseda:	le, MD	21237
Patel, Babyboy	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, Ite M. 2008.		20a. Method of Dis 1 Burial 2 4 Donation	☐ Cremation	3 □Removat from Secify) in St	State	Place of Dispo cemetery, crea	osition (Nami matory or oth	e of her place	θ)	Date	20c. Loc	ation - City or T	own, State
tel Balti	permit. Departn Importa any inju			uneral Service L		irector		ate A		my 212		. Balt	imore S	Street
(S)			23a. P. tt1. Enter shock, or he	the disease, or o	complications that cannot one cause on e	aused the deat	19				c or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause disease or conditi	(Final	EV	+ ren	ne T	Dre w	101	urity				Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as a conseq	uence of):	1 -11	1-1	19				
	LAdillilei		Sequentially list co	onditions,	b. — Chris F. I	or as a consec	mores of							
	ted	ulu	Sequentially list of it any, leading to cause. Enter Und Cause (Disease of that initiated event	lerlying r injury	53510 (O 23 & 5011300	14 011 0 0 01).							
	ate be executed hysicien and the burial-transit	Examiner	that initiated event resulting in death)	ts Last	c. Due to (or as a conseq	juence of):							
760,	sicier b buri	calE		1	d =									
an an	rtificate ng phy as the	9			1									
Вох	ath certif	Physician/M	IF FEMALE: 23b. Was deceded in the past 12			come of pregnation 2 Feta	Il death 3[Ectopic pre				23	3d. Date of deliv	rery Day Year
Ö	it the de by the a	yslo	1 ☐ Yes 2 9 ☐ Unknow		9□ Unkno		104111 31	_Other (spe	city)					
S, P	ires that the signed by	۵	Part II. Other sign	ificant condition	ns contributing to de	eath but not res	sulting in the u	inderlying ca	use give	en in Part I.		\ \	/	the cause of death?
0.00	w require been si should l	etec											·	
Division of Vital Records, P.O. Box 6	has has	Completed									24a. Wa aut per 1 🗆 Yes	opsy formed?	prior to co death?	opsy findings available ompletion of cause of
/ita	ician: Th certificate ector, paç	Be	25. Was case refe examiner?	erred to medical	Hospital: 4				Oth		ath Check only	one		
of	Physical this call dir	2	1 Yes 2				ER/Outpatie			4 Nursing	Home 5 Res			fy)
u	ding I h. After tuner	tlon	1 Natural	5 Pending		of Injury th, Day Year)	Injury	M	Bc. Injury Work	k? Yes 2 □ No	28d. Describe	s now injury	occurred	
<u>:s:</u>	of or Attendiate of after death. Director: A din by the fu	flca	2 Accident 3 Suicide	6 Could n	ot be 28e, Place	of Injury - At h	ome, farm, st						Number or Rur	al Route Number,
D.	s after al Dire	Certification;	4 🗍 Homicide	Getermin	buildi	ng, etc. (<i>Speci</i>	fy)				City or To	own, State)		
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physician: To the xaminer: On the band man	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	th occurred a livestigation,	it the tim	ne, date and plac pinion, death occ	e, and due to the urred at the time	e cause(s) a e, date and p	and manner as s place, and due t	stated. to the cause(s)
	To the within To the comp	Σ	29b. Signature an	d title of certifier	eout	elu	8	29c.	License	e number		29d. Date	signed (Month,	Day, Year)
			30. Name and add	dress of person v	vho completed caus	se of death (Ites	n 23a) (Type	Print)	, <u>- ,</u>	(0.	Λ		
		ate	31. Date filed (Mo		and the	JCVCI egistrar's Sign	1000 ature	rank	lin	gruale	Vrive	Balti	more n	- 0 6 10 21237
4	Regist	rar	A	UG 0 1 2	טטט פטט.	مر درون	1							

DHMH 17 Rev 1/2001

		_ 1	For State Registrar	State of Marylan		artment rtificate				iene	000	5 24038
-			Decedent's Name (First, Middle, Last)						2. Date of Dea	th		3. Time of Death
	Physicia		Clara Lois F	eebles					Month JUL	Y 27,	200E	8:50 PM
/	/Medic Examin		4a. Facility Name (If not institution, give so Saint Joseph M	reet and number) ledical Cen	ter	4b. City, To	own, or Loca	Tows	חכ	4c. Coun	ty of Death Balt	imore
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. 8		If Under 1 Months		ours Min.	8. Date of Birth (Month, Day May 28,	Year)	Col	nplace (State or Foreign untry) SSISSIPPI
	D >	-	Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	cation						10d. Inside City Limits
	within 72 hours after death with the Maryland ene. Than "naturel", or Itema 23a or 28a-f ehow he Medical Examinar must be notified at	ŏ	MD Baltimo			sex						1 ☐ Yes 2 No
	the N	Director	10e. Street and Number			10f. Zip C	Code			0g. Citizen o	f What Cor	untry?
	with with	급	939 Woodlynn Ro	ad			221			USA		
	eath maga	Funeral		2. Was Decedent Ever in U	.S. 13.	Was Decede	nt of Hispan	ic Origin? (Sp	ecify Yes or No- Rican, etc.)			rican Indian,
	ter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No					Rican, etc.)		lack, White	
ğ	urs a	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	L }4 No Sp	ecity:		Spec	₩Whi	.te
Ç	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Usual	Occupation	g most of work	king	16b. Kind of	Business/I	ndustry
7	thin the	npidu	Elementary/Secondary (0-12)	College (1-4or 5+)		maker				own h	ome	
2	filed wi Hygien other th	S	12th		nome			Mothoda Nam	e (First, Middle,			
	be fill H of of off	Be	17. Father's Name (First, Middle, Last) Claude Monroe	Gravson					Hudson	maidel Jum	1110/	
$\frac{2}{3}$	should be filed within 72 hours after death with the Marylan of Menual Hygiens. Tanked other than "nature!", or Itema 23a or 28a-f show marked other than "nature!" or Itema 23a or 28a-f show marke event, the Medical Examinar must be notified at	၉			10h Maili	na Addross I			ral Route Numbe	r City or Tow	n State 7	In Code)
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic evonce.		19a. Informant's Name/Relationship (Type Anita Lois Hess						d Balti			21221
e)	1 and Healt em 2		20a. Method of Disposition	20b. F	Place of Dispo	osition (Name	e of		Date	20c. Location	n · City or	Town, State
Baltimore,	ages nt of nt of t: If it		1 Burial 2 ☐ Cremation 3 ☐ R	emoval from State Oa	cemetery, cre. K Law	matory or off 'n Cen	neter	y 7/3	1/06	Balti	.more	e MD
≣	rtane ortani ortani		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	ne O	11/12	2. Name and	Address of	Facility 3 (00 Mace	Δνο	Bal	to MD
Ва	Depa Impo eny i		Tonas	1 (00000	Olis							x 21221
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ations that caused the deal	th. Do not en							Approximate Interval Between
	Dharisian		Immediate Cause (Final									Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consec		HKLI	LUN					
Н	Examiner			HYPOTENSI								
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):							
W	d d ansit	Examiner	Cause (Disease or injury that initiated events									
7.092	te be executed ysicien and e burial-transit		resulting in death) Last	Due to (or as a consec	quence of):							
92		Cai		l								
68	ng ph as th	Med	IF FEMALE:									
Вох	th ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta	aldeath 3	□Ectopic pre					Date of deli Month	ivery Day Year
0	e dea	Sici	1 ☐ Yes 2 X No 9 ☐ Unknown	4 Pregnant at time of of 9 Unknown	death 5	Other (spe	ecify)					
<u>G</u>	d by letech	by Physician/Med	Part II. Other significant conditions cor	stributing to death but not re-	sulting in the s	underlying ca	usa nivan in	Part I.	23e. Did to	bacco use co	ontribute to	the cause of death?
	The law requires that the death certifica its hes been signed by the attending ph tage 2 should be deteched for use as it	۵	Paren, other signment contains to	and the second second		, .	g		1 🗆 1	es 2 □ No	3 🗆 Pr	obably 4 Vunknown
5	neen Ponlo	etec							24a. Was	24	h Wara ai	itopsy findings available
Vital Records,	hes t	Completed							autop		prior to death?	completion of cause of
a E						-		DI	1 Yes	2 No	1 🗆 Yes	2/2/No
ΖĔ	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital: 1 Unpatient 2	7.50/0	ent 3 DO	Other		ith <i>Check only o</i> lome 5 ☐ Resid		Other /See	c(h)
	Phys rahdi rahdi	7	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time		Bc. Injury at Work?	+ C Nuising H	28d. Describe I			cny)
9	ding h. Afte	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м		2 🗆 No				
Division of	Attending r death. sector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At I	nome, farm, s	treet, factory	, office		28f. Location (S City or Tox		mber or Ru	ural Route Number,
ă	after after I Dire	Certification:	4 Homicide	building, etc. (Spec	iry)				Ony or rov	in, olulo)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, dea	th occurred a estigation,	at the time, o	date and place on, death occu	, and due to the irred at the time,	cause(s) and date and plac	manner as	s stated. to the cause(s)
	To the within 2. To the I complet	Mec	29b. Signature and title of certifier	/	/,	29c	License nu	mber		29d. Date sig	ned (Mont	h, Day, Year)
	⊢ s ⊢ ŏ		11/1	Vhorand.	10 he	mi	D 463	556		Tuly	27.	2006
	10		30. Name and address of person who co	completed cause of death (Ite	C	71			0			
	V		KHOSROW TABASS				IVE T	OWSON	MARYLI	S QNP	1204	
4	St	ate	31. Date filed (Month, Day, Year)									
	Regist		Auc 0 1 200	32. Aegistrar's Sign	15. P.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) TuBER T eea **Physician** 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner A Medical Baltimore Baltimor (enter If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 27, - 22 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 1 XM 2 ☐ F 78 Yrs Pennsylvania 219-22-3554 Director 0 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. ther then "nature!, or iteme 23a or 28a.4 show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other then "naturel", or items 23a or 28a-f show other traumetic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 ☑ No **Funeral Director** Baltimore Riverview 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4230 Hollins Ferry Rd. 21227 U.S.A. U 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Amed Folces: 1 ⊠ Yes 2 □ No If Yes, Give 1 2 - 5 - 52 Year or Dates: 12 - 4 - 54 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiene importent: if item 27 ie marked other the eny in jury or other traumetic event, that once. 11 Security Guard Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hubert Alton Peed Elizabeth Shepperd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 S. Longwood Street Baltimore MD 21223 Robert Peed, Sr./Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State Hubert 20a. Method of Disposition 1 ☐ Byrial 2 ☑ Cremation 3 ☐ Remeval from State West Arundel 4 □Opnation 5 □ Other (Specify) 7-31-2006 Odenton MARYLAND 22. Name and Address of Facility
Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd. Arbutus MD 21227 21. Signature of Funeral Service Licenses 23a. Parti. Enter the disease or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-translt Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by to d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ carcinoma 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy med? 1 Yes After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No death. 2 Accident investigation al or Attend s after death il Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 12-11571 nelissa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAKAR ION GREENE MeLiss 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Marylan		artment of Heal			iene _{eg. No.} 20	06	24	040
			1. Decedent's Name (First, Middle, La	st)				2. Date of Dear Month		Year	3. Time of	Death
	Physicia /Medic		Emma	Loretta		Peltzer		July 30			2:55	a ^M
	Examin	_	4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, or Loca	ation of Death		4c. County o	f Death		
			Westminster	Nursing Home		Westmins			Carr	o11		
	Funeral			Sex 7. Age (In yrs. 1 ☐ M 2(2XF 9.1			Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day	Year)	Birthpla Countr	ice (State o	r Foreign
	Director		218-12-4151	1□M 2(XF 81	Yrs.			Sept 13,	1924	Mary	land	
	pu s		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	eation				100	d. Inside Ci	ity Limits
	laryla sho	ō		imore	_	isterstown					1 🗆 Yes	•
	he N	ect	10e. Street and Number	Thore		10f. Zip Code		1	0g. Citizen of Wi	hat Countr	n/?	
	with a	ᡖ		m1			106				· y ·	
	within 72 hours after death with the Maryland ene. Then "neturel", or items 23e or 28e-f show Te Medical Examiner must be notified at	Funeral Director	103 Glyndon Dr	12. Was Decedent Ever in U	S 13		136	acify Yes or No-	U.S.A	American	n Indian	
	itan Itan	١٩	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕱 No	.0.	Was Decedent of Hispan If Yes, specify Cuban, Mo	exican, Puerto	Rican, etc.)		, White, et		
99	irs af	<u>م</u>	3 XWidowed 4 Divorced	If Yes, Give Year or Dates:	:	1 ☐ Yes 2⊠ No Sp	pecify:		Specify:	Wł	nite	
21215-0036	2 hou	Completed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupation			16b. Kind of Bus	iness/Indu	ustry	
7	nin 7	pie	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of work done during DO NOT use retired)	g most of worki	ing				
7	r the	E	12	College (1-401 04)	В	ookkeeper			Wilbur	Funk	Comp	any
ğ	e filed other	Be C	17. Father's Name (First, Middle, Las.)		18.	Mother's Name	e (First, Middle,	Maiden Sumame))		
<u>a</u>	Aenta Aenta rked rked tic e	To E	Grant F.	Renna			Mary	K. Fren	ch			
ary	2 should be f and Mental I ie marked of		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street and N	Number or Rura	al Route Number	, City or Town, S	itate, Zip C	Code)	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Deportment of Health and Mental Hygiene. The man are also the man and the man are also the man and the man injury or other traumatic event, the Madical Examinar must be notified at once.		Joseph W. French,	Jr. Cousin	4611	Linden Aven	ue Bal	ltimore,	Mary1an	nd 2	1227	
J.	of He item		20a. Method of Disposition		Place of Dispo	esition (Name of matory or other place)		Date	20c. Location - C	city or Tow	n, State	
Ĕ	Pages nent of I nnt: if it		1 ☐ Burial 2 ② Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci	_Hemoval from State	-	Cremation S	er 7/31	/06	Hampstea	d. Ma	arv1aı	nd
att	mit. pertmoorts y inju		21. Signature of Funeral Service Lice			2. Name and Address of			sterstor			
m	Depermination of the contract		Stephen	c M. Lenk	cus E1	ine Funeral					136	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	pplications that daused the deat				· ·		-	Approximate	
	Physician		Immediate Cause (Final	One cause on each line.	K	18057 10	ncel				Onset and [
1	/Medical		disease or condition resulting in death)	a Due to (or as a consec	uence of):		. 10-1			\rightarrow	XXX	
	Examiner											
		ē	Sequentially list conditions, if any, leading to in mediate	Due to (or as a conseq	uence of):							
10	ured d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
0,4	exec en an rial-tr	EX	resulting in death) Last	Due to (or as a consec	juence of):							
8760,	law requires that the death certificate be executed es been signed by the ettending physicien and 2 should be detached for use as the burial-transit	cai		d.								
89	tifica ng ph as th	led										
Box	that the death certif ed by the ettending detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			1	of delivery		
	deal de ett ed fo	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of o		Other (specify)			Mon	:n D	Day 1	Year
Q.	at the by th	, h	9 ☐ Unknown	3CI OTIKTOWIT						-		
S,	res tha igned to be det	by	Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause given in	Part I.		bacco use contril			
Records,	w requir been si should	le d						1 🗆 Y	es 2.⊠No :	3 Probat	bly 4 □L	Jnknown
ပ္ထ	e law re hes be je 2 sho	pie						24a. Was a	n 24b. W	ere autops	sy findings a	available
œ	The ste he	Completed						perfor	ned?> de	eath?	2□ No	
Vital	ian: rtifice stor, 1	BeC	25. Was case referred to medical			26.	Place of Death	h (Check only or				
>	ysic lis ce direc	10 6	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Other: 4	Nursing Ho	me 5 Reside	ence 6 Othe	r (Specify)		
اه ر	Attending Physician: r death. sctor: After this certific by the funeral director.		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injury at Work?		28d. Describe h	ow injury occurre	d		
<u>.</u>	ath.	atic	2 ☐ Accident investigation	on		M 1 ☐ Yes	2 🗆 No					
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, st	reet, factory, office		28f. Location (S. City or Town	treet and Numbe n, State)	r or Rural I	Route Num	ber,
	tai or rs efte ei Dir	Cer										1
	Hoepital	edicai		hysician: To the best of my knominer: On the basis of examina								()
	- W - W		one)	and manner stated.								,
	To the within To the comple	Σ	29b. Signature and title of certifier	10110		29c. License nur			9d. Date signed	(Month, Di	ay, Year)	
			John	Chare m		500	59943		Joix	3112	000	1
	_		30. Name and address of person who	completed cause of death (Item	m 23a) (Type,	Print)						
	1/2		John (Proe)	MO 295 5	Trey	Are Suit	30	1 mes.	miniter	W	211	57
		ate	31. Date filed (Manth Gay (Year) 21	Registrar's Sign	arure	we						
	Regist	TEST			1							

06-05142 Maria Roy

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 2404

		1- For State Certificate of Registrar	Death	eg No
Physicia	in/	Decedent's Name (First, Middle,Last)	Date of Deat Month	Day Year
edical Exami	ner	Maria Roy	July 17, 20	006' 1321 nrs
		,	b. City, Town, or Location of Death Baltimore City	4c. County of Death
		Maryland General Hospital		th(MM/DD/YYYY) 9. Birthplace (State or unk
Funeral		5. Social Security Number un 6. Sex 7. Age (In yrs. last birthday)	11 11 10 11 11 11	Foreign
Director	L	1 M 2X F 45 Yrs.	Months Days Hours Min. Jan 1	, 1961 Country)
2	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on	10d. Inside City Limits
) w. ari				1 X Yes 2 No
Maryland 28a-f show any d at once.	호	MD Baltimore	10f. Zip Code	Og. Citizen of What Country?
ne Mary or 28a	Director		21217	USA
ith the Maryland 23a or 28a-f sho notified at once.		822 Newington Avenue 11 Marrial Status UNK 12 Was Decedent Ever in U.S. 13 Was		
215-0036 be filed within 72 hours after death with the Maryland half Hygiene. half of other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once.	Funeral		s Decedent of Hispanic Origin? (Specify Yes or No es, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
er des		1 Yes 2 No	Yes 2 No specify:	Specify black
ırs afi ural'	<u>a</u>	or Dates:	t's Usual Occupation (Give kind of work don UTI)	
2 hou	اچ ا		ost of working life. DO NOT use retired)	
36 thin 7 te. than edica	힐	unk unk		
5-0C ed wit lygier of her	Completed	17. Father's Name (First, Middle, Last)	unk 18.Mother's Name (First, Middle, N	Maiden Surname) unk
21215-0036 Mod be filed within 72 hours after a filed within 72 hours after marked other than "natural", or event, the Medical Examiner.	Be			
Z 5 6 6 2 1	의	l	Address (Street and Number or Rural Route Num	
e, MD 2121 I and 2 should be f Health and Mental item 27 is market r traumatic event.			Penn Street Baltimore,	
nore, MD 2 ages I and 2 shou nt of Health and N tt: If item 27 is n other traumatic		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State crematory or oth	ition (Name of cemetery, Date ner place)	20c. Location - City or Town, State
Page:		4 Donation 5 X Other Specify: in state		
Baltimore, permit. Pages I ar Department of Her Important: If ite	1	21. Sime of uneral servaticensee Wage Misector Sta	te and Address of Faction and 655 W.	Baltimore Street
W 8 9 E	_	Ball Ball	timore MD 21201	
Physician	- 3	23a. Part Enter the disease or complications that eaused the death. Do not enter the failure list only one cause on each line.	ne mode of dying, such as cardiac or respiratory arm	Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Narcotic intoxication		Death
		or condition resulting in death) Due to (or as a consequence of):		
	Ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	л П	cause Enter Underlying Cause (Disease or injury that initiated		
d sit	Examiner	events resulting in death) Last Due to (or as a consequence of):		
executed an and al - trans		XUNPENDED AMENDED it con#232 27 282-f		
760, icate be exe physician a	/Medical	1001#200,21,2001	,perME,g858.8/2/2006 TT	Table 1
3760, fit cate be g physic	M/	IF FEMALE: 23b. Was decedent pregnant in the post 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fel	tal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
Box 687 e death certificathe attending ed for use as t	Physiciar	past 12 months? 4 Pregnant at time of death 5 Oth	her (Specify)	1
Bo; e deat the att	hys	1 Yes 2 No 9 V Unknown 9 Unknown		
P.O. s that the gned by e detach	by P		and only mig decade given min and	obacco use contribute to the cause of death?
s, P.C uires that signed d be deta			(s 2 No 3 Probably 4 ✔ Unknown
ords, v requir s been s	lete		24a. Was	prior to completion of cause of
eco he law ate has age 2 s	Completed		perfo	rmed? death? 2 No 1 ✔ Yes 2 No
Division of Vital Records, tal or Attending Physician: The law require aster cleath. In Director: After this certificate has been siled in by the funeral director, page 2 should be		25. Was case referred to medical	26.Place of Death (Check only one)	
Vita ysicia his ce direc	o Be	examiner? 1 Very 2 No Hospital: 1 Inpatient 2 VER/Outpatient	3 DOA Other Nursing Home 5	Residence 6 Other:
n of ing Ph After t funeral	٦: -	27. Manner of Death 28a. Date of Injury 28b. Time of In		how injury occurred
for fendi eath. or: /	atio	Natural 5 Pending Fnd 7/17/2006 Fnd 12:4	4 am · 1 Yes 2 X No unk	
ViSi or Atı fiter d Direct in by	ertification	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street	et, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City State) 822 Newington Avenue
Dj spital ours a reral l	Cert		e Baltimore	MD022 New Ingcorr Average
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur (Check only	rred at the time, date and place, and due to the caus	se(s) and manner as started.
To the Hos within 24 h To the Fun	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigated		
	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		Toulloni - Tollie	O.C.M.E.	July 18, 2006
		30. Name and address of person who completed cause of death (Item 23a)	444 Donn Street Bellin BAD 0400	1
		Patricia Aronica-Pollak MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 2120	1
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature,	pole	

		4	State	partment of Health and M Certificate of Death		ene . No 2006	24042
			Registrar 1. Decedeni's Name (First, Middle, Last)	oranoato or Doute	2. Date of Death		3. Time ol Death
	Physicia	an	Claire M. Russell		July 29,	Day Year	2:00pm M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	0	4c. County of Death	
	LAGITITI	Ŭ.	127 E. Randall Street	Baltimore			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Davs Hours Min.	8. Date of Birth (Month, Day, Y April 20,1	(ear) 9. Birth	place (State or Foreign intry)
	Director	-	220–36–2532 1 M 2 F 66 Yrs	S.	April 20,	1940 Balt:	imore,MD
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the county	r Location			10d. Inside City Limits
	Mary	to	MD - Bal	timore			1 XYes 2 □ No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	intry?
	within 72 hours after death with the Maryland offer. or items 23a or 28a-f ahow the Mardical Examiner must be notilled at	aD	127 E. Randall Street	21230		USA	
	dear dear	Funeral	11. Marital Slatus 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	or it	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Wh	ite
Ş	hours tural	q pa		ecedent's Usual Occupation	16	Sb. Kind of Business/le	ndustry
7.	in 72 n "ne	Completed	(Specify only highest grade completed) (C	give kind of work done during most of work. fe. DO NOT use retired)	ing	Own Home	,
212	d with giene.	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		OWIT HOME	
פ	al Hyg	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	aiden Sumame) U√	K
<u>ya</u>	Menta Menta arked	2	Paul Keyser				
Maryland 21215-0036	2 sho			lailing Address (Street and Number or Rura 7 E. Randall St. Ba			ip Code)
a)	1 end 1ealth nm 27 ther t			isposition (Name of	Date 20	c. Location - City or 1	own. Slate
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Brainlet of Health and Trianmatic avent, the Madical Examinar must be notified at any injury or other traumatic avent, the Madical Examinar must be notified at any injury or other traumatic avent, the Madical Examinar must be notified.		Cemetery,	crematory or other place) en Memorial Park 2006	+ 7	len Burnie M	
Balt	permit. Departr Importa		21. Signature of Funeral Survice Licensee	22. Name and Address of Facility Charles L. Stevens FU 1501 East Fort Ave Ba	heral Home Altimore MD	Inc. 21230	
			23a. Part. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between
J.	Physician		, -,	TONY FAILV	RF		Onset and Death
1	/Medical		resulting in death)			2 6-	- 12
л	Examiner		Sequentially list conditions	TIVE LUNG	11156	ASE	VI
	87 E	luei	if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury	;			,
	cate be executed physicien and the burial-transit	Examiner	that initiated events c				
8760,	sicien buris	dical E					
687	fficate g phy: as the	edlo	V				
Вох	death certific e ettending p id for use as	M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 ☐Ectopic pregnancy		23d. Date of deli-	,
œ.	thet the death certific ed by the ettending p detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death	5 Other (specify)		Month	Day Year
0	et the 1 by th stach	جُ	9 L Unknown		One Didunte	cco use contribute to	the serves of death?
ŝ	S F 6	٥	Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.			bably 4 Unknown
Ö	w require been si should I	ompleted			24a. Was an	24h Wara 211	loney lindings available
Rec	has has	E G			autopsy performe	ed? death?	opsy lindings available ompletion of cause of
a		e Co	25. Was case referred to medical	26 Place of Deat	1 Yes 2 In (Check only one)		2 1 No
Ē	Physician: this certific ral director,	0 B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	Other		ce 6 □Other (Spec	ufv)
o			27. Manner of Death 28a. Dale of Injury 28b. Time	ne ol 28c. Injury at	28d. Describe how		
Ö	Attanding r death. actor; After by the fune	atlo	2 Accident Investigation	M 1 Yes 2 No			
Division of Vital Records,	l or Attan after deat Diractor; in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - Al home, larn building, etc. (Specify)	n, street, lactory, office	28l. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director; completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.				
	To the within 2. To the Complete	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month	n, Day, Year)
)	i		I MA	11/9640	7	131/00	2
	6		30. Name and address of person who completed cause of death (Item 23a) (TMANCS NOVER W)	ype, Print) Y7 S HANON	En S	7.	
	Sta	ate	31 Date filed (Month Day Year) 3 Registrar's SignAvire	parle			
	Regist	rar	AUG 0 1 2006 Boxes 15 19				

	-	For State	_	ype or Prin State of Ma		d / Depa	artme	nt of H			/gien	е	э.	
		Registrar					unca	le oi	Deatti	0.0044.010	Reg. N	0)	6	2-1-0-1-0
Physician		Decedent's Name (Fi		C		חור				2. Date of D Month	D	ay Ye		3. Time of Death
/Medica	1	FRANC		S.		146	LLY	T	al and an of Dark	July	2	, -00		09184
Examine	r	ta. Facility Name (If not					40. Cit		r Location of Deat		4	c. County of E BAC		O.R.F.
		NORTHWE		OSPITAL	n /In was I	and highdays	If I lod	er 1 Year	ALLSTOWY		rth			
Funeral Director		5. Social Security Numb 216-16-650 Usuel Residence of Dec	7 1底	M 2□F 7. Age	82	ast birthday) Yrs.	Months		Hours Min.	8. Date of Bi (Month, D Oct. 2	av, Yea 0 ,]	923	Count	ace (State or Foreign ry) MD
land Dw	-		o. County	-	10c. City	, Town or Lo	cation						10	d. Inside City Limits
Mary	ğ	MD Ba	altimore		Owi	ngs Mi	.11s							1 ☐ Yes 2 🛣 No
the 28s	9	10e. Street and Number			1		10f. Z	ip Code			10g. C	itizen of Wha	t Count	ry?
3a o	5	4 Fleming	ham Cour	•t				2111	7		U	.S.A.		
ms 2	Funeral Director	11. Marital Status		2. Was Decedent I Armed Forces?	Ever in U.S	S. 13.	Was Dec		lispanic Origin? (S an, Mexican, Puer	pecify Yes or N	0-	14. Race - /		
D36 urs after of the property	2	1 Never Married 3 Widowed 4	2 Married	Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	ν₩WΙΙ			ecify Cuba 2 <mark>∏</mark> No	Specify:	o Hican, etc.)		Specify:		
O S Po	ē		Decedent's Educa			16a. Dece	dent's Us	ual Occup	ation	4.5.	16b.	Kind of Busin	ess/Ind	ustry
215 in 22	Completed	(Specify of Elementary/Secondary	nly highest grade	Completed) College (1-4or 5	141	life.	DO NOT	vonx done use retired	during most of word)	rking				
The gians	E	12	y (0-12)	Conego (1 401 a	,	Sup	ervi	sor			T	e1epho:	ne (Company
D E E E E	To Be	17. Father's Name (Firs Francis R							18. Mother's Nar Anna I	_{ne (First, Middle} Katherir				
sho was		19a. Informant's Name	Relationship (Type	e, Print)		19b. Mailir	ng Addre	ss (Street	and Number or Ru	iral Route Numi	ber, City	or Town, Sta	te, Zip	Code)
Muld 2		Virginia :	Rielly -	Wife		4 F	lemi	ngha	m Court,	Owings	Mi1	1s, MD	21	117
Baltimore, Misperial Land 2 Department of Health 2 Important: If New 27 is any injury or other transmission.		20a. Method of Disposit 1 ☐ Burial 2 A ☐ 4 ☐ Donation 5 ☐	remation 3 Re	moval from State	Car	lace of Dispo emetery, crer roll C	sition (N matory or CO • C	ame of other plac rema	tion 7-2	Date 29-06	16	Location - City mpstea		
Balti permit. Deportm Importa any inju		21. Signature of Funda	Pervice Licenses	39	2.					line Fur			രണ	, MD 21136
76C B be be Sicie	dicai Examiner	23a. Part1. Enter the d shock, or heart fa mediate Cause (Final disease or condition resulting in death) Sequentially list condition and the cause. Enter Underlying Cause (Disease or injurt that initiated events resulting in death) Last	al Ca.	Due to (or as Due to (or as	a consequence	perce of):	condi	ani	et					Interval Between Onset and Death
cords, P.O. Box 687 w requires that the death certificate been signed by the ettending phys should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 Yes 2 No 9 Unknown	nths?	c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3[∃Ectopic ∃ Other (pregnancj specify)	1			23d. Date of Month		y Day Year
	þ	Part II. Other significar	nt conditions cont	ributing to death b	ut not resu	ulting in the u	inderlying	cause giv	en in Part I.					e cause of death? ably 4 \textbf\(\sum\)Unknown
has has	Completed										opsy ormed?	prior deat	to con	sy findings available apletion of cause of
	0	25. Was case referred	to medical	1 (300_75) 250_ 5	- 181 W - C	S 280 (15) (11-17-1-7	gerter :	26. Place of De		/			
f Vita	To B	examiner? 1 ☐ Yes 2⊠No	Ho	spital:	ent 2 🗆	ER/Outpatier	nt 3 🗆 [DOA Ott	er: 4 🗆 Nursing H	lome 5 ☐ Res	idence	6 Other (Specify)
On of ording Physis.: After this stuneral di		27. Manner of Death	☐ Pending investigation	28a. Date of Inju (Month, Da	iry	28b. Time o Injury		28c. Injui Wor 1 [28d. Describe				
Divisio	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of Inj building, et	ury - At ho c. (Specify	ome, farm, str	reet, facto	ory, office		28f. Location City or To	(Street a	and Number o	r Rural	Route Number,
	Medical C	29a. Certifier 12 (Check only 2	Certifying Physi Medical Examina	cian: To the best er: On the basis of and manner sta	f examinat	wiedge, deat tion and/or in	h occurre	ed at the til on, in my o	me, date and place opinion, death occ	e, and due to the urred at the time	cause((s) and manne nd place, and	r as sta due to	ated. the cause(s)
o the	₹ S	29b. Signature and title	of certifier				2	29c. Licens	se number		29d. D	ate signed (N	fonth, L	Day, Year)
F S F 8) O			(am			De	005077		6	July :	25	2006
		20 None	of possess who		loath (Itom	2221 / 75	Drine*	V	059736		_0	1	-	
941		30. Name and address	WATSO	N . M . D	,	NORT	HWES		HOSPITAL	5401	D	60 CO	JRT	ROAD
State Registra		31. Date filed (Month, I	n 1 2006	Je Agusti	Si o Signa	ture								

ORIGINAL

			1 - For State Registrar	State of Ma		/ Depa		t of H	ealth a		•		711116	24044
			1. Decedent's Name (First, Middle, La	ist)							2. Date of De	ath Da	/ Year	3. Time of Death
	Physici /Medio		Anthony J.	Rotondi							July	30	2006	5:30p M
	Examir	_	4a. Facility Name (If not institution, gir		_				Location of	of Death		4c.	County of Deat	
			Continuum Care	At Sykesvil	le		Syke	esvi	11e			Ca	arroll	
	Funeral				(In yrs. las	t birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th	9. Birt	hplace (State or Foreign
	Director		033-10-1303	¹ X ^{M 2□} F 8	9	Yrs.	IVIOTICIS	Duys	710013		eb 20			
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	r								444 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4
	arylan show	_	Md Carroll	and the state of t	-	esvil								10d. Inside City Limits
	the Maryla 28a-f shor	Sct												1 Yes 2 No
	든 호텔	Funeral Director	10e. Street and Number				10f. Zip					10g. Cit	zen of What Co	untry?
	ath w	-B	4210 Jefferson				2178						ISA	
	ter dea Items ITELM	rue	11. Marital Status	12. Was Decedent E		13.	Was Deced	dent of Hi	spanic Ori n, Mexican	gin? (Spec i, Puerto R	cify Yes or No Rican, etc.))-	 Race - Ame Black, White 	
36	or l	by F	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No	1941		1 ☐ Yes		Specify:				C'4.	
21215-0036	72 hours "naturel", olical Exc		3 ₩ Widowed 4 Divorced	Year or Dates:									W 11	ite
5	72	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	dent's Usua kind of wor	rk done d	luring most	of workin	g	16b. Ki	nd of Business/	Industry
12	within ene. then "	ם	Elementary/Secondary (0-12)	College (1-4or 5+			DO NOT us		•			f	n i +	
2	lled v tygie her 1		12 17. Father's Name (First, Middle, Last			Lurni	ture	reii			(Final Adiabata		niture	
Maryland	ges 1 and 2 should be filed withir it of Health and Mental Hygiene. If item 27 is marked other than or other treumatic event, the M	Be	Joseph Rotondi	,							(First, Middle,		Sumame)	
3	ould Mer Marks	ို				_		-			Sciarn			
lar	2 sh and is rr		19a. Informant's Name/Relationship		100								r Town, State, Z	
	of Health item 27 other tr		Janet Gensor (dau	ignter)	4	4210	Jeite	erson	Ave.	., Sy	kesvil		Md 2178	
5	of H of H if ite		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □	Removal from State	20b. Plac	e of Dispo etery, cren	sition (Nan	ne of ther place	9)	Da	ate	20c. Lo	cation - City or	Town, State
<u>Ē</u>	Pag ment: ant: ury		*4 ☐ Donation 5 ☐ Other (Special		Fishl		Rura1			Aug 3	2006	Fis	hkill,	NY
Baltimore,	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Lice	nsee		22	. Name an	d Addres	s of Facilit	y Haig	ht Fun	era1	Home &	Chanel
Ω	89 = 8		> Waige Haight	ofunout		6.	О. Бо	x 19	5 Syk	esvi	11e, M	d 21	784	onaper
1760,	death certificate be executed Wedical Ex A factor use as the burial-transit	ical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c. Due to (or as a	consequen	nce of):	rdio,	my	орч	lly			M	Interval Batween Onset and Death
P.O. Box 68	D 0 D	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal de	ath 3	Ectopic pro					2	23d. Date of deli Month	very Day Year
	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions	contributing to death but	not resultir	ng in the ur	nderlying ca	ause give	n in Part I.		23e. Did to			the cause of death?
Records,	9 L 9	Completed										med2	prior to c death?	topsy findings available ompletion of cause of
Vital	ician: Th certificate rector, pag	O	25. Was case referred to medical						26 Place	of Death /	1 ☐ Yes (Check only o	2 No	10163	2010
5	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital:	2 □ FB	/Outnation	* 3[] DO	Δ Othe	-			11	i □Other (Spec	···64)
of	Phy or this		27. Maneer of Death	28a. Date of Injury (Month, Day		b. Time of	_	8c. Injury Work	_		3d. Describe t			ny)
o	ding th.	ţ	Natural 5 ☐ Pending 2 ☐ Accident investigatio		Year)	Injury	м		? ′es 2.⊟1	40		•		
Division	or Attending after death. Director: Aftel in by the fune	Certification:	3 Suicide 6 Could not be determined	e Oga Diaga of laive	y - At home (Specify)	, farm, stre	eet, factory				3f. Location (5 City or Tox			rel Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) 29a. Certifying Pl	nysicien: To the best of niner: On the basis of e and manner state	xamination	dge, death and/or inv	occurred a	at the time in my op	e, date and inion, deat	d place, an	nd due to the	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	ithin o the	Mec	29b. Signature and title of certifier	wid mailing state			290	. License	number			29d. Date	e signed (Month	Dev. Year)
ì	F ≯ F 8		1111-1	, /									1-1-	/
	6		Witte 4	6 ND			1	100	128	137		//	31/01	==
	1		30. Name and address of person who	completed cause of dea	ath (Item 23	Ва) (Туре.	Print)	-, -		4 1-	4	-1-	1100	
			Willy Mus	245 5	one	- H	115	+ 35)/	WRS	Tonins	Te.	NO 21	157
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 1 20	32 Registrar			الما							

			State of Maryland / Dep 1- For Amend #26 Per FH G858 8/01/2	artment of Health and Notificate of Death	dental Hygier	0000	24045
	Physicia	an	1. Decedent's Name (First, Middle, Last) Sydney Hurlbut Renehan Jr.			Day Year	3. Time of Death
,	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July 25	2006 4c. County of Death	2:45a M
			3043 Deep Valley Dr.	Westminster		Carroll	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 12 of 69 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yes June 30 1		ace (State or Foreign try)
	yland 10W		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L			10	Od. Inside City Limits
	Ba-f et	Director	MD Carroll Westmin				1 ☐ Yes 2 ☐ No
	with the	Dire	10e. Street and Number 3599 Nicholson Road	10f. Zip Code 21157		Citizen of What Coun USA	try?
36	should be filed within 72 hours after death with the Maryland and Menall Hygiene. marked other then "natural" or items 23a or 28a-f ehow marked other then "natural" or items 24a or 28a-f ehow imatic event, the Medical Examinar must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2x ☐ No	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: whi	etc.
21215-0036	vithin 72 hou ne. hen "natural e Medical E	Completed I	15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4cr 5+)	dent's Usual Occupation s kind of work done during most of work DO NOT use retired) /operator of truck	ring	. Kind of Business/Ind	
ณ	filed v Hygie other t	e Co	4 OWNER 17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		TOIL
/lan	should be ind Mental marked o	To Be	Sydney Renehan Sr.	Mary El	Lizabeth B	arcus	
Ž	s 1 and 2 should of Health and Men Item 27 is marks other traumatic		19a. Informant's Name/Relationship (Type, Print) Kimberly Wetzelberger (daughter) 3043	ing Address <i>(Street and Number or Rui</i> Deep Valley Dr.,	ra <i>l R</i> oute <i>Number, Cit</i> Westminst	y or Town, State, Zip er, MD 211	Code) 57
altimore,	of Hei		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition cemetery, cree	osition (Name of matory or other place)	Date 20c	Location - City or To-	wn, State
Ē	permit. Pages Department of Important: If It eny injury or o		4 □Donation 5 □Other (Specify) Crest La	wn Memoria $1\sqrt{7-28}$ -2. Name and Address of Facility $ ext{Haj}$		rriottsvil	
Ba	Department of the partment of		▶ Jaige Haight Spribert P	.O. Box 195 Sykesy	ville, Md		
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enshook, or heart failure. List only one cause heach line. Immediate Cause (Final disease or condition resulting in death) a	ter the mode of dying, such as cardiac	or respiratory arrest,	Ø.	Approximate Interval Between Inset and Death
∞ .	hysicien and hite burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
.O. Box 6	that the death certifica ed by the attending pt detached for use as ti	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
۵.	w requires that been signed b should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute with	e cause of death?
al Records,	Attending Physician: The law requires that the rideath. •ctor: After this certificate has been signed by the the funeral director, page 2 should be detached.	Completed			24a. Was an autopsy performed	prior to con death?	osy findings available inpletion of cause of 2 No
ZE Z	sician s certifi irector	o Be	25. Was case referred to medical examiner? 1 Yes / 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othor	th (Check only one)	6 XX ther (Specify	Daughter's
Division of Vital	To the Hospitel or Attending Physicien: The law within 24 hours elter death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	-	27. Man of ath 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) Injury		28d. escribe how in		Home -
Divis	5 # F =	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	tand Number or Rura tate)	l Route Number,
	To the Hospital within 24 hours e To the Funeral completely filled	edicai (29a. Certifier Certifying Physician: To the best of my knowledge, dea (Check only one) Medical Examiner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	, and due to the cause rred at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	29c. Impense number (29d.	Date signed (Month, I	Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type		1/20	1 4 4	2463
	Sta	ite	31. Date filled (Month, Day, Year) 2. Registrar's Signature	enter Street,	Westmins	tr. MD	21157
4	Regist		AUG-0 1 2006 Blown B. Ago				

Registrar

7/29/2006

The adore Rosenhang

		-	For State Registrar	State of Maryland / Depa	artment of Health and Nartificate of Death		ne, 2006 24047
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physicia	an		shman Shank		July 30), 2006 6:50 pm
	/Medic Examin	-	4a. Facility Name (If not institution, give si		4b. City, Town, or Location of Death	July	4c. County of Death
	Examin	eı	Ivv Hall Geriat:		Middle River		Baltimore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		212-24-3653 ^{1X0}	M 2	Months Days Hours Will.	7/31/19	28 Maryland
	P .		Usuel Residence of Decedent	10c. City, Town or Lo			10d. Inside City Limits
	aryla hov	_	10a. State 10b. County	roc. City, Town of Ec	Callon		1 ☐ Yes 2 💆 No
	8a-f	Directo	Maryland Baltimore	e Middle Ri		100	Citizen of What Country?
	with t	D	10e. Street and Number	- 1	10f. Zip Code		•
	• 230	Funeral	1824 Wilson Point		21220 Was Decedent of Hispanic Origin? (Sp		S. A.
	er de Item	'n	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
36	rs aft	by F	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give 1948 Year or Dates: 1950	1 ☐ Yes 2 X No Specify:		Specify: White
5-0036	tura etura	ed	15. Decedent's Educ	ation 16a. Dece	dent's Usual Occupation	168	b. Kind of Business/Industry
2	nin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) (Give life.	kind of work done during most of work DO NOT use retired)	ang	
2	d with	E O	10	Owne	er / Operator	S	porting Goods
פ	othe vent,	Bec	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Mai	iden Sumame)
<u>a</u>	Alenta Alenta rked tic e	ToE	Albert Shank		Eva	Harshman	
Maryland 2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "netural", or Iteme 23s or 28s-f show say follury or other traumatic event, the Modical Exportment has notified at once.		19a. Informant's Name/Relationship (Typ	e, Print) 19b. Maili	ng Address (Street and Number or Ru	ral Route Number, C	ity or Town, State, Zip Code) 21221
Ž	and 2 palth n 27 i		Margaret Ann Shank		4 Wilson Point Roa		River, Maryland
Baltimore,	of He		20a. Method of Disposition 14 Burial 2 ☐ Cremation 3 ☐ Re	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Date 200	c. Location - City or Town, State
Ĕ	Pag ment: i		4 □Donation 5 □ Other (Specify)	Bel Air	Memorial Gardens	2006 Be	l Air Maryland
a	Departr Import eny Inje		21. Signature of Funeral Service License	e 2	2. Name and Address of Facility Bruzdzinski Funera	l Home PA	
<u> </u>	\$9 E 2 9		Michael C. Ja	Alian Sr	1407 Old Eastern A	venue Es	sex, Maryland 21221
п			23a. Part1. Enter the disease, or complication shock, or heart failure. List only on	ations that caused the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	atherus	lerotic Card	iovaso	clar Dx. 10 Llear
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			"
	Examiner		Sequentially list conditions, if any, leading to immediate				
_	pe sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
0	and I-tran	хап	that initiated events c	Due to (or as a consequence of):			
8760,	cien buria						
87	law requires that the death certificate be executed es been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medical					
9 X	ding se as	/Me	IF FEMALE:	3c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy □ Other (specify)		Month Day Year
o	the d	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown			
0.0	that ed by deta	Į.	Part II. Other significant conditions con	tributing to death but not resulting in the i	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
ds	uires sign ld be	d by	Cerebro	was cu Car o	acciolent	1 ☐ Yes	2 ☐ No 3 ☐ Probably 4 ☐ Unknown
ö	v req beer shou	ete				24a. Was an	24b. Were autopsy findings available
Vital Records,	The lav	Completed				autopsy performe	d? prior to completion of cause of death?
ā	ician: Th certificete rector, pag	e Co	25. Was case referred to medical		26 Place of Dea	1 ☐ Yes 2X th (Check only one)	No 1 Yes 2 No
₹		0	examiner?	ospital: 1 Inpatient 2 ER/Outpatie			ce 6 Other (Specify)
ð	문문	7. To	27. Manner of Death	28a. Date of Injury 28b. Time		28d. Describe how	
O	ding Ih. Th. After funer	후	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	M 1 Yes 2 No		
Division	Attending it death.	Fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, s	treet, factory, office	28f. Location (Stree City or Town,	et and Number or Rural Route Number,
á	afor affer	Certification:	4 Homicide	building, etc. (Specity)		City of rown,	State)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical ((Check only 2 Medical Examin	sician. To the best of my knowledge dea ner: On the basis of examination and/or in			
	To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		I. Date signed (Month, Day, Year)
	5 × 5 0	-	250. Signature and title of certifier	Hon D. N	1/ 0/	230	-1216
,	1.1			10	H 35593		1/3/2008
	Ht,			mp eted cause of death (Item 23a) (Type		7 / 1/4	0 0 100
	\ 		31. Date filed (Month, Day, Year)	32. Registrar's Signature	E BUE, BAL	70. M	D. 61221
	St Regist	ate rar	AUG 0 1 2008	Lever Is so	arti		

			For State Registrar		State of	Marylan	-	artment of F		d Mental Hy	0	000	21.01.0	7
			Registrar Decedent's Name	(First, Middle, I	ast)			Tuncale of	Dealli	2. Date of De	Reg. No.	UUD	3. Time of Death	1_
	Physici		John	r (i mot, imadio, E	.431/			Smith		Month	Day	Year 2006	15 100	М
	/Medic Examin		4a. Facility Name (If	f not institution, g	ive street and nun	nber)		4b. City, Town, o	or Location of D	Death	4c. C	County of Death	10-101	
	LXamii		The John	us Hor	olains 1	Hospit	aL	Bulti	more	City				
	Funeral		5. Social Security Nu		Sex 1□XM 2□F	7. Age (in yrs. i		Months Days	If Under 24 Hours	Min. 8. Date of Bi	rth av, Year)	9. Birth	place (State or Foreigntry)	gn
	Director		242-54- Usual Residence of		11.3.W. 2	69	Yrs.			June2	9,19	37	NC NC	
	iand ow		10a. State	10b. County		10c. City	y, Town or L	ocation					10d. Inside City Limit	ls
	Man Man	ţo	MD	Balt	imore	E	ssex						1 ☐ Yes 2 🔯 N	Ю
	or 284)irec	10e. Street and Nun					10f. Zip Code				en of What Cou	ntry?	
	ath wi	rai	8 Horn	ney Cou	ırt			21221			US			
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 le marked other then "naturel", or Iteme 23a or 28a-f ehow or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Marrie 3 Widowed	ied 2☐ Married 4X Divorced	Armed For	2	.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	dispanic Origin an, Mexican, F Specify:	? (Specify Yes or Note of Record Rican, etc.)		4. Race - Amer Black, White Specify: Whi	, etc.	
5-0	72 ho	etec	(Speci	15. Decedent's	Education grade completed)		(Giv	edent's Usual Occup e kind of work done	during most of	working	16b. Kind	d of Business/Ir	ndustry	
121	within ne. ihan	Completed	Elementary/Secon		College (1	-4or 5+)	Sal	DO NOT use retire	d)		Car	pet		
	Hygie ther ant,		12th 17. Father's Name ((First, Middle, La	st)		1		18. Mother's	Name (First, Middle	, Maiden S	iumame)		
lan	ould be i Mental I arked o	To Be	John R	R. Smit	h				Luna	a G. Cre	ech			
Maryland	2 should be filed within and Mental Hygiene. Ie marked other then raumatic event, the Mental count, the Mental count cou	-	19a. Informant's Na	•				•		or Rural Route Numb	. ,		о <i>Code)</i> 21221	
	1 and Health em 27 ther tr	i ji	Doug Ko		JI./SC	20h P	lace of Disc	osition (Name of	1	Road Bal		ation - City or T		_
altimore,	Pa ant: ury	1	The second secon	Cremation 3	□Removal from : cify)	State Pai	emetery, cre uline	matory or other pla Baptis		3/3/06	Four	r Oaks	NC	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Fu	Turs	n Cos	mel	Vu C	onnelly	Funer	300 Mac	of I		to. MD 21221	
			23a. Part1. Enter the shock, or hear	ne disease, or co	mp eations that c	aused the death	not er	nter the mode of dyi	ng, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between	
	Physician	8 1	Immediate Cause (disease or condition	(Final		NINST							Onset and Death	S
	/Medical Examiner		resulting in death)	1		or as a consequ							71	_
	<u> </u>	<u></u>	Sequentially list con	nditions,	b. Due to	r as a conseq	N. Contraction	. \$					1 day	5
	De led	nlne	Sequentially list cor if any, leading to im cause. Enter Union Cause (Disease or	injury	Q.	-	- 100 OI).	Sec. 1.					1 wa	1
	al-trai	Examine	that initiated events resulting in death) L	5	U	or as a consequ	ue of):	hona					· · · · · · · · · · · · · · · · · · ·	
8760,	icate be executed physician and the burial-transit	dicail			d									
9		Medi	JE 551441 5											
Вох	th cer tendir rr use	an/N	IF FEMALE: 23b. Was decedent			come of pregna		□Ectopic pregnanc	у		23	3d. Date of deliv	,	
O. E	that the death certific ed by the attending p detached for use as	Physician/Me	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4□Pregn 9□ Unkno	ant at time of down		Other (specify)				Month	Day Year	
α.	that the	Phy	Part II. Other signifi		contributing to de	eath but not resi	ulting in the	underiving cause gr	ven in Part I.	23e. Did	tobacco use	e contribute to	the cause of death?	
Records,	Se G	ed by								1_	Yes 2 ☑	No 3□Pro	bably 4 Unknow	'n
000	aw requir s been si 2 should l	Completed								24a. Wa		24b. Were aut	opsy findings availab empletion of cause of	le
R	sician: The law certificate has t irector, page 2 s	mo;								— auto perf 1 ☐ Yes	ormed?	death?		
Vital	ysician: is cartifica director, p	BeC	25. Was case reference examiner?	red to medical		/			26. Place of	Death (Check only				
of V	> 0 0	2	1 ☐ Yes 2 ☐				ER/Outpatie	ant 3 DOA		ng Home 5□Res			(y)	
no	ng fte	iuo!	27. Manner of Death 1 □ Natural	5 Pending		of Injury th, Day Yeer)	28b. Time Injury	Wo		28d. Describe	how injury	occurred		
isio	l or Attending after death. Director: After I in by the fune	icat	2 Accident 3 Suicide	investigat	be age Blace	of Injury - At he	ome farm e	M 1	Yes 2 □ No		(Street and	Number or Rus	al Route Number,	
Division	after Direct	Certification:	4 🗌 Homicide	determine	buildi	ng, etc. (Specif	y)	treet, lactory, office		City or To	wn, State)	realition of Fig.	ar riodio riomodi,	
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	1 ☐ Certifying 2 ☐ Medical Ex	eminer: On the ba	best of my kno asis of examina her stated.	wledge, dea tion and/or i	th occurred at the ti nvestigation, in my	me, date and popinion, death	place, and due to the occurred at the time	cause(s) a , date and p	and manner as	stated. to the cause(s)	
	o the	Me	29b. Signature and	title of certifier	and mail			29c. Licen:	se number		29d. Date	signed (Month,	Day, Year)	
	-		> U	J / de	un '	M.D.		REC	5-0	00	Ju	1, 20	1,2006	
	10		30. Name and addr		no completed caus	e of death (Iten	n 23a) (Type	, Print)				0		
	==		Wesley		600 N	louth U	volte	Street	Bal	timore 1	MD	212	287	
	Sta Regista		31. Date filed (Mon	nth, Day, Year) UG 0 1 2	3470	egistrar's Signa	ture	arle						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 15A M ichard TRUBIN JULY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center BALTIMORE Hospice ow son JIII Chrest If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 7 8 Yrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral M 2□ F Days Hours Months 212-22-0491 Director June 20, 1928 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director BALto PARKUILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 262 21234 U.S.A or Itams 23a NenDaver Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1₽76s 2 □ No U.S. If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced ARMY and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Colfege (1-4or 5+) Elementary/Secondary (0-12) FORK OPERATOR 10+L Mol DCCAFT. NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George STRUBIN MARGARET Fuller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Depertment of Health a Important: If Itam 27 la sny injury or other trak RD. BA HO MO MASA STRUBIN 2621 Wendover 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 29/06 Lutherville 4 Donation 5 DoTher (Specify) EnTombreat Dulaney Valley 21 Signature of Funeral Service Licensee

22. Name and Address of Facility

23. Name and Address of Facility

23. Name and Address of Facility

24. Name and Address of Facility

25. Name and Address of Facility

26. Name and Address of Facility

27. Name and Address of Facility

27. Name and Address of Facility

28. Name and Address of Facility

29. Name and Address of Facility Approximate Interval Between Onset and Death Colon Immediate Cause (Final Canar **Physician** Mars disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No isral Director: After this certificate has been signed by the atter filled in by the funeral director, page 2 should be deteched tor Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 20ther (Specify) W Spice 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1- Natural 5 Pending within 24 hours efter death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Registrar DHMH 17 Rev 1/2001

0

State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 0 1 2006

30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

M

32. Registrar's Signature

CHAPLES

Medical

N.

6601

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Charles

Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as states.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

58303

Barmore

29d. Date signed (Month, Day, Year)

July 27

m 21204

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 - 24051 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 3.44A.M JUI KINGER /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 2□ F Months Days Hours 212-38-111 Yrs. Director 28 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits worle in then "natural", or itema 23a or 28a-f ehov the Medical Examiner must be notified at HARFORD 1 ☐ Yes 2 ☐ No Director Forest 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA ZaFunerai 21050 12. Was Decedent Ever in U.S. Armed Forces? 1 15 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 □ No Specity: Specify: þ WINTE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) e, Maryland 212 ROLANT 12 s 1 and 2 should be filed w f Health and Mental Hygier item 27 is marked other th other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RANCES Man oese 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health au Important: If item 27 is any injury or other trau ianau 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition
1 △ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City r Town, State Date Air Mem Gardens 8-2-06 4 ☐ Donation 5 ☐ Other (Specify) Del 22. Name and Address of Facility 3 NEW PORT N, FUREST HILL, 21. Signature of Funeral Service Licensee EVANSFUNGRALCHAPTEC-BEL AIX. MD 21050 em beil plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and cause on each line. 23a. Part 1. Enter the disease of or m shock, or heart failur x. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician myocardna /Medical Due to (or as a consequence of): **Examiner** Owla years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co uence of): Examiner physiclen and s the burial-transit Due to (or as a consequence of): Physician/Medicai attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à cate has been sig , page 2 should b 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No lipidemi certificate has pertension 1 Yes 2 No 25. Was cas oferred to medical Hospitel or Attending Physicien: director 26. Place of Death | Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ EV/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To this After this funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deati To the Funerel Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Medicai 🗎 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 31 36425 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aam FAIL, MD 4 C North A verwe 4 C. North Avenue 31. Date filed (Month, Day, Year) 32 registrar's Signature State AUG 0 1 2006 Registrar

			1 - For State Registrar	State of Marylar	•	artment of He rtificate of De			ene 3. No. 2006	24052
	Physici	_	1. Decedent's Name (First, Middle, Last) Young In Sohn				2	2. Date of Death Month JULY	29, 2006	3. Time of Death 11:05 PM
	/Medic Examin		4a. Facility Name (If not institution, give s Saint Joseph h	treet and number) Medical Cen	ter	4b. City, Town, or Lo	Towsor	n .	4c. County of Death Balt	imore
	Funeral Director		5. Social Security Number 6. Sex 212-70-1176	7. Age (In yrs. 75	last birthday) Yrs.		Hours Min.	3. Date of Birth (Month, Day,) ECEINDER	9. Birth 20, 1930 S	place (State or Foreign ntry) eoul, Korea
	and w	Ì	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Maryl B-f ehc	tor	Maryland Baltimore	Ti	monium					1 ☐ Yes 2 ☐ No
	th with the 23a or 28 ist be not	al Director	10e. Street and Number 25 Lovett Court			10f. Zip Code 21093			g. Citizen of What Cou nited State	-
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow important: if Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow appringny or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 222 No If Yes, Give Year or Dates: 	1	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☒ No	panic Origin? (Spec Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - Amer Black, White Specify: KOY	, etc.
15-0	n 72 ho natur	ieted	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occupation kind of work done dur DO NOT use retired)	on ring most of working]	6b. Kind of Business/Ir	ndustry
212	d within giene. or then	omo	Elementary/Secondary (0-12)	College (1-4or 5+) N/A	Cler	ζ		E	noch Pratt	Library
and	be filed ntal Hygid od other event,	Be	17. Father's Name (First, Middle, Last) Unknown				8. Mother's Name (Unknown	First, Middle, Ma Kim	aiden Sumame)	
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other then saumatic event, the Mental terms.	To	19a. Informant's Name/Relationship (Ty			ng Address (Street and	d Number or Rural		City or Town, State, Zi	p Code)
	l and 2 tealth a mm 27 to her tra		Mr. Tony J. Sohn	to the common of		ovett Court			and, 21093 Oc. Location - City or T	Court State
Baltimore,	Pages I		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	Du Du	lan ey v	osition (Name of matory or other place) Va.1 Ley Mem	Aug, 1	,2006 T	imonium, M	aryland
Ball	permit. Page Depertment of Important: If eny injury or		21. Signature of Funeral Service License ### The Property of Puneral Service License #### The Property of Puneral Service License ##################################	Jan. s.	P 2	Name and Address Baceful Al 325 York R	ternative oad Timor	es Funer nium, Ma	al&Cremati ryland 210	on Ctr.,P.A 93
			23a. Rant. Enter the disease, or compli struck, or heart failure. List only or Immediate Cause (Final				such as cardiac or	respiratory arres	et,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	quence of):					
П	Examiner	_	Sequentially list conditions,	Due to (or as a conse		TRICAL A	CTIVITY			
\	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ACUTE MYC		AL INFAR	CTION			
68760,	ficate be executed physicien and is the burial-transit	al Ex	resulting in death) Last	Due to (or as a conse	quence of):					
		Medical	IF FEMALE:							
P.O. Box	the death certifi y the attending ched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknowh	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)	N. E		23d. Date of deliv Month	ery Day Year
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions cor	stributing to death but not re	sulting in the u	nderlying cause given	in Part I.	23e. Did toba	cco use contribute to	the cause of death?
of Vital Records,	The law ete has b page 2 st	Completed						24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:	1.5B/0 · · ·	Other	26. Place of Death			
on of	the field	tion: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 🔯 Inpatient 2 🗆 28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injury a Work?	4 Nursing Home	e 5 Hesiden 3d. Describe how	ce 6 Other (Speci vinjury occurred	<i>ħ</i>)
Division	a or Atten efter deal Directors d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, strify)	reet, factory, office	28	Bf. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	edical C		sician: To the best of my kn ner: On the basis of examin and manner stated.						
	To th withir To th comp	Me	29b. Signature and title of certifier	a Par 44 x		29c. License r		1 .	d. Date signed (Month,	
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	2			LOU, M.D.,	7601	OSLER DR	IVE, TO	WSON, I	MARYLAND	21204
	Sta Regist		31. Date filed (Month, Day, Year) ÄUG 0 1 200	32 Aegistrar's Sign	di de	arle				

			1 - State of Maryland / Dep	artment of Health and in the state of Death		ene 2006	24053
3	6		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		Janice Carol Swartz		Month 7	27 2006	1103 ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Deat	
Organia.		Art of	Bowie Health Center	Bowie If Under 1 Year If Under 24 Hrs.	O Date of Burth		George
	Funeral Director		5. Social Security Number 058-32-7676 6. Sex 1 \(\to M \) \(\text{M} \) \(\text{XT} \) F 6. 4 \(\text{Yrs.} \)	Months Days Hours Min.	8. Date of Birth (Month, Day, 1)	(ear) Co	hplace (State or Foreign untry) ew York
407.5			Usual Residence of Decedent		10-23-1	1741 1	
	show		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
2	Ba-f.	octo	MD Prince George Bowie				1 ▼ Yes 2 No
	B or 2	Dir	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	ountry?
-	i /2 hours after death with the Maryla "natural", or leans 23a or 28s-f shou olical Examinat must be muilied at	Funeral Director	13544 Youngwood Turn 11. Marital Status 12. Was Decedent Ever in U.S. 13	20715 Was Decedent of Hispanic Origin? (S	Specify Yes or No-	USA 14. Race - Ame	nican Indian,
,	or Iten	Fun	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	to Rican, etc.)	Black, White	
3	rali, o	1 by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specity:		Specify: W	Mhite
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4	withir ane. than	ф	Elementary/Secondary (0-12) College (1-4or 5+)	omemaker		Own H	Iomo
V :	Hygid Hygid Sther ent,		17. Father's Name (First, Middle, Last)		me (First, Middle, Ma		ione
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or liems 23a or 28a-f show reumatic event, the Medical Examinar must be nutified at	To Be	Earl Robert Gross	Ade1	aide Geral	ldine Reus	sow
ב ב ב	shou s mar			ing Address (Street and Number or Re			Zip Code)
	and 2 salth a n 27 l			44 Youngwood Turn			-
5	permit. Pages 1 and 2 should be tiled within 72 no Department of Health and Menial Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Mcdical once."		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	rmatory or other place)		oc. Location - City or	Town, State
	ment tant:		4 □Donation 15 □Other (Specify) Chesape		29/2006	Beltsvill	e, MD
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65		-	23a. Part1. Enter the disease, or complications that caused the death. Do not en	933 Cist Ave Si	lver Sprin	no MD 2091	Approximate
	e di		shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arteriosclerot	ic Cardiovascular			Interval Between Onset and Death
ľ	hysician /Medical		disease or condition resulting in death) ATTETTOSCIETOU a. Due to (or as a consequence of):	ic cardiovascurar	Disease		
E	Examiner		Coronary Arter	y Disease			
· /	g /b/ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	6.24			
	sicien and burial-transit	Examiner	that initiated events				
3	be ex iclen burial		Due to (or as a consequence of):				
2	physi s the t	dicai	d				
*	death certifica attending ph d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	ivery
á :	death e atte	icia	in the past 12 months? 1 Yes 2 Thus 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year
	w requires that the death cer been signed by the attendin should be detached for use	hys	9 Unknown		-		
ົ້	es the	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to	
5	requir	ted	Chronic Hypertension		1 Yes	2 No 3 Pr	obably 4 ⊠tynknown
0	has b	Completed	High Cholesterol		24a. Was an autopsy performe	prior to	topsy findings available completion of cause of
<u> </u>	r: The				1 Yes 2 €	Zingo 1 ☐ Yes	2 No
= :	sicien: Th certificate rector, pag	Be c	25. Was case referred to medical examiner? Hospital: Hospital:	Othon	ath Check only one		
5 i	Phys or this aral dii	: To	27. Manner of Death 28a. Date of Injury 28b. Time	HIL SIXDON 4 INdishing F	28d. Describe how	ce 6 Other (Sperinjury occurred	city)
5	nding ath. r: Afte e fune	ertification:	1 ⊋Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
2	Affe or deg octor	iilca	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre	et and Number or Ru State)	ural Route Number,
5	itel or rs afte ei Dii	Cer					
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 42 hours after death. Within 54 hours after death. To the Funneri Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, dea (Check only one) 2 ☑ Medical Examiner: On the basis of examination and/or and manner stated.				
	o the ithin 2 o the omple	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	290	d. Date signed (Monta	h, Day, Year)
	⊢ ≯⊢̃ŏ		> Musterell MO	D0007967		7-28-2006	
	10		30. Name and address of person who completed cause of death (Item 23a) (Type				
	Ψ.			. Ft. Washington	MD 20744		
	Sta		31. Date filed (Month, Day, Year) ALIG 0 1 2006	ule			
	Registr	ar	AUG 0 1 2006 Kleine & 19				

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	Physicia /Medic		1. Decedent's Nam	e (First, Middle	e, Last)	helma	a E. S	oelle	rs			Mon	of Deeth th y 29	Dey 2006	Year		ne of Death 25 P.M.
1	Examin		4a Fecility Name (Multi	Care Ce	nter					Bal	, or Location of timore		4c. County N/A			
	Funeral Director		5. Social Security N 218-01-32 Usuel Residence o	90	6. Sex 1 □ M 2 □		ge (In yrs. Id 90	ast birthday, Yrs.	Months I	Year Days	If Under 24 Hours	Hrs. 8. Date Min. (Mon Mar	of Birth th, Day, Yo Ch 14	1,1916	9. Birthpl Count Mar	lace (Sta try) ylar	ate or Foreign
	Meryland In show	tor	10a. State MD	10b. County N/A			10c. City	, Town or L Balt	ocation imore						10		le City Limits Yes 2 \(\text{No} \)
	th with the 23e or 28	Funeral Director	10e. Street end Nu 1132 Rol	and Hei	ights A	venue)		10f. Zip C	ode	2	1211	10g	. Citizen of		try?	
980	Jrs a	۾	11. Marital Status XXNever Marr 3 Widowed		ied 1 1	Decedent ed Forces Yes 2 X s, Give r or Dates:	06		Was Deceder If Yes, specify 1 ☐ Yes 2 ∑		spanic Origin n, Mexican, F Specify:	? (Specify Yes Puerto Rican, et	or No- c.)	14. Rad Bla	ce - America ck, White, e	etc.	1,
Baltimore, Maryland 21215-0036	d within 72 ho giene. Ir then "netu	Completed	(Speci Elementary/Seco 7th		st grade comple	eted) ege (1-4or	5+)	16e. Dece (Give life.	dent's Usual (kind of work DO NOT use Engine	Docupa done d retired) ROC	tion uring most o	f working		b. Kind of B Hutzl		-	re
/land	should be filed within nd Mantel Hygiene. marked other than ", umatic event, tre Mes	To Be C	17. Father's Neme	(First, Middle,		enry	Soell	ers			18. Mother's Julia	Name (First, M a	liddle, Mai	iden Surnan	ne)		
, Mar	CENL		19a. Informant's No Michael	Dodge (305 1	Moonlid	aht		or Rural Route N Balto	, MD	2122	5		
timore	t of talk		20a. Method of Disp 1 XXurial 2 I 4 ☐ Donation	☐ Cremetion 5 ☐ Other (Sp	pecify)	rom State	Holi	ace of Disponent Company Cree	osition (Name matory or othe SEMET	of er place eme	tery	8/1/0		Location -	-	wn, State)
Baj	permit. Pa Depertmen Important: any Injury		21. Signature of Fu	what	Come	zir	to	B ₁	osi rai	lens .ls	s-Seii Road	tz Fune: Balto,	MD	21211	Inc.		
	Physician /Medical		Immediate Cause (Final														mate Between nd Death
	Examiner	Ē	disease or condition resulting in death)		ө	15	Due to (or	ANIC as a consec	QUENCE Of):	r L	conc	gopert.	77			42	47
/ •		Examiner	Sequentially list coif eny, leading to imcause. Enter Unde Ceuse (Diseese or	nditions, imediate rlying	b		Due to (or	as a consec	quence of):					-			
Box 68760,	± 00.00		that initieted events resulting in death) I		d		Due to (or	es e consec	juence of):								
	the etter	Physician/M	Part II. Other signifi	icant conditio	ns contributing	to death t	out not resul	lting in the u	nderlying ceus	se give	n in Part I.	23b.	Did tobac	CCO USE CO	ntribute to	the cau	ee of death?
ls, P.0	grae bed	2	nepha	- pnc	umon.	ia,	811	ADH	, 15ch	ein	ic	_	1 Yes	2□ No	3 ☐ Probe	ably 4	⊠n known
of Vital Records,	The law requires thet tha daath certiata has been signed by the ettending page 2 should be detached for use e	Completed	nephra	path	7						_	24a.	Was en au performed	utopsy 1?	avai com	lable pri	sy findings or to of cause
E			05 146										1 🗆 Yes	2 1 No	10	Yes 2	!□ No
₹	5 00	0 26	25. Was case referr examiner? 1 ☐ Yes 2 △		Hospital:		ent 2 🗆 E	R/Outpatier	nt 3 DOA	Other		Death (Check on the character) Death (Check of the character)	-	e 6 □Oth	er (Snecity))	
ion oi	£ £ w	27. Menner of Death 1/ Relatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury Nort? 28c. Injury at Work? 1 Yes 2 No										njury occurr					
Division	tai or Attencts effector:	Cermic	3 ☐ Suicide 4 ☐ Homicide	6 Could n determi	ned 200. F		iury - At hon c. (Specify)		eet, factory, of	ffice			ion <i>(Stree</i> i r Town, Si	t and Numb tate)	er or Rural	Route N	umber,
	To the Hospital within 24 hours e To the Funeral C completaly filled	edical	29a. Certifier (Check only one)	A Certifying 2 ☐ Medical E	xaminer: On the	the best ne besis of menner sta	f examinetic	ledge, deeth on end/or inv	occurred at to vestigation, in	he time my opi	, date and p nion, death o	ace, and due to occurred at the t	the cause ime, date	e(s) and ma and place, e	nner as ste and due to t	ted. the caus	e(s)
	Vith Common Comm	Σ	29b. Signature end	title of certifier	lin				29c. Li	icense 5	number 830	3	29d.	Date signed	3/ a		
	(o		30. Name end eddre	1	who completed of	. /	leeth (Item 2	1 /1	Print)	St	BA	nnor	o M	0 2	1204		
	State Registra		31. Date filed (Mont	h, Day, Year) IG 0 1 2	2006	Registr	er's Signatu	50	ill.								

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5 PerState of Manyland, Department of Health and Mental Hygiene FH g858 8/15/06 Certificate of Death Reg. No. Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) STOKES LORRAINE 12:34 PM JULY ZOCE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death RANDALLSTOWN NORTHWEST HOSPITAL **Baltimore** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Nu 681 3 1 □ M 2 🗶 F Yrs 227-56-6613 78 September 04,1927 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ▼No Maryland Baltimore Windsor 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 25 Bishops Gate Court 21244 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Neudecker Lorraine Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 40 Pops Lane,

20b. Place of Disposition (Name of cemetery, crematory or other place) 40 Pops Lane, Great Cacapon, West Virginia 25422
ce of Disposition (Name of Date 20c. Location - City or Town, State Ann Shade 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 07/31/06 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. Baltimore, Md. 21229 22. Name and Address of FacilityLoring Byers Funeral Directors, Inc 21. Signature of Funeral Service Lifenses 8728 Liberty Road, Randallstown, Maryland 21133 Olles MOOJJJ 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) URINARY TRACT INFECTION Due to (or as a consequence of): STONE URETERAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? RENAL FAILURE

Physician /Medical Examiner

attending physicien and for use as the burial-translt

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signed

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certificate

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ospital or Attending Physhous after death.
Ineral Director: After this y filled in by the funeral d

To the Hospital within 24 hours a To the Funeral C

Be

2

Certification:

Medical

Attending Physician:

the

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

Director

r 28e-f ehow

a filed within 72 hours after deeth with It Hygiene.
other then "naturel", or Items 23a or vent, Ina Medical Exammer ment the

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 1e marked othn eny injury or other traumatic event, 9064.

Director

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Completed

deeth with the Maryland

Examiner Completed by Physician/Medical IF FEMALE 9 I Inknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2/2 No 1 Tyes 2 DONO

25 Was case referred to medical 2) No 1 T Yes 27 Manner of Death

5 Pending

investigation

1) Natural

2 Accident

3 ☐ Suicide

Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Yeer)

28b Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No М 28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 Could not be 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D54355 29d. Date signed (Month, Dey, Year) 29 2006 JULY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIRCEA TODOR RANDALLSTOWN NONTHWEST HOSPITAL SHOT OLD COURT ROAD

State Registrar

31. Date filed (Month, Day, Year) AUG 0 1 2008



		1 - For State Registrar	State of Ma	aryland / D	epartmen Certificat			ınd Mer		iene g. No.	06	240)55
		1. Decedent's Name (First, Middle, Last)						2.	Date of Deat Month	h Day	Year	3. Time of	Death
Physic /Medi		Beatrice Elizab	eth Sau	iter				Ju	ı1y 31	, "200	6	1:00	A. M
Exami		4a. Facility Name (If not institution, give stre	et and number)		4b. City,	Town, or I	Location of	f Death		4c. Count	•		
		Fairhaven N. H.					ille				rrol.		
Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birth	Months	1 Year Days	If Under 2 Hours	Min. 8.	Date of Birth (Month, Day,	Yeer)	9. Birthi	place (State o	r Foreign
Director		215-01-0666	202	90 '	rs.			Αυ	igust 1	6,1915	Ma	ryland	
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				· · ·			10d. Inside Ci	ty Limits
Manyl 1 sho	ō	Maryland Carroll		Sv	kesville	2						1 ☐ Yes	2 No
the 28a	Directo	10e. Street and Number			10f. Zip				1	0g. Citizen of	What Cou	intry?	
38 or		7200 3rd Avenue				21784			Und	ted St	otos	of Am	orion
DESILITIOTE, INIGITY ISLICE A. I. 23-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at any injury or other traumatic.	Funeral		Was Decedent I Armed Forces?	Ever in U.S.	13. Was Deced	ent of His	spanic Orig	gin? (Specify , Puerto Ric	y Yes or No-	14. Ra		ican Indian,	<u> </u>
after or the		1 Never Married 2 Married	1 Yes 2 X	10	1 ☐ Yes	-	Specify:	, , a dito 1 110	an, oto.,		_{fy:} White		
June 1.	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:										
72 h	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. I	Decedent's Usua (Give kind of wo life. DO NOT us	il Occupa ik done di	tion u <i>ring m</i> ost	of working		16b. Kind of B	iusiness/Ir	ndustry	
A the first in the	пp	Elementary/Secondary (0-12)	College (1-4or 5	+)	Secreta		'		V	<i>l</i> arfiel	.d-Do	rsey	
Hygie		17. Father's Name (First, Middle, Last)	2		Decree		18. Mother	r's Name (F	First, Middle, M	Maiden Sumai	 me)		
d be ontall	Be C	Walter Franklin Sa	uter				Maud			rman	,		
shoul nd Me mark	2	19a. Informant's Name/Relationship (Type	, Print)	19b.	Mailing Address	(Street at	nd Numbe	r or Rural R	loute Number	City or Town	, State, Zij	p Code)	
Michael Ithar		C. Thomas Richarts		ew) 1	Silktre	e Cou	ırt. (Catons	ville.	Marv1	and :	21228	
T. Hea		20a. Method of Disposition		20b. Place of	Disposition (Nar	ne of		Date		20c. Location			
Page: ento nt: If		1 Psurial 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	noval from State	Lorrain	ne Park	Ceme	tery	08/04	4/06 W	lood1aw	m, Ma	ary1and	1 2120
mit. Pages partment of portant: If it it it y injury or o ce.		21. Signature of Funeral Service Licensee	1/		22. Name an	d Address	s of Facility	y Lorin	o Rvei	s Fune	ral l	Directo	ors. Tr
Depariment important		Lylendalon	Homm	111.0 3	8728 L								
		23a Part 1. Enter the disease or complica shock, or heart failure. List only one	tions that caused	the death. Do no	ot enter the mod	e of dying	, such as	cardiac or re	espiratory arre	est,		Approximate Interval Bets	A
Physician	Н	Immediate Cause (Final disease or condition	() a	entra							L	enset and I	Death
/Medical		resulting in death)	12	a consequence o	f):							1000	
Examiner		Sequentially list conditions b.											
₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of	f):								
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the d	ıysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown										
The law requires that the death The has been signed by the atter sage 2 should be detached for u	by Pt	Part II. Other significant conditions contr	buting to death b	ut not resulting in	the underlying o	ause give	n in Part I.		23e. Did tob	acco use con	tribute to t	the cause of d	eath?
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s bee	Completed								24a. Was a	n 24b.	Were auto	opsy findings a	available
The lar	l Lo								autops perforr 1 Yes 2	ned?	death?	2□ No	1056 0
VITAI ician: T certificat ector, pa	a)	25. Was case referred to medical					26. Place	of Death (C	Check only on	-			
ysic ysic	To B	examiner?	spital: 1 🔲 Inpatie	ent 2 ER/Out	patient 3 DC	Othe	T 4 Nu	rsing Home	5 🗆 Reside	ince 6 □Ot	her (Speci	ify)	
n OI ng Phy Iter this		27. Mapner of Death 1 Matural 5 ☐ Pending	28a. Date of Inju (Month, Da		ime of 2	8c. Injury Work	at ?	280	d. Describe ho	w injury occur	rred		
DIVISION I or Attending after death. Director: Afte	Satle	2 Accident investigation			М	1 🗆 Y	res 2□N						
or Att	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injude	ury - At home, fan c. <i>(Specify)</i>	m, street, factor	, office		28f.	Location (St City or Town	reet and Num. i, State)	ber or Rur	al Route Num	ber,
oital o	O			Constant									
Hosp 24 ho Fune tely fi	edical	29a. Certifier Check only one) Certifying Physic 2 Medicel Examine		examination and)
DIVISION OI VIIII INC. To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2	Med	29b. Signature and title officertifier,	and maimer St	4,04.	290	. License	number		2	9d. Date signe	ed, (Month,	Day, Year)	
7 × × 8	1	1/1/ (11	ĥ	0	1	200	0	120	,	7/2	101	,	
		30. Name and address of person who com	pleted cause of d	eath (Item 23a) C	Type, Print)	noo,	381	17/		121/	Np		
10		July 1	295 5	toner	Avo C	21	77	1x 1000	tribe	Lor .	mo	Zn.	5
S	ate	31. Date filed (Month, Day, Year)	32. Pagistr	ar's Signature	V- C 27		4	VVC.Z	1-1-113				-
Regis		AUG 0 1 200	6 Acres	w St.	poste	1							

Please Type or Print in Black Indelible Ink Letrice Smith State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 0634 hrs Medical Examiner Letrice N. Smith July 23, 2006 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Northwest Hospital Randallstown **Baltimore County** If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) Months Days Hours Director 09/09/1983 Country) 213-06-2828 1 M 2X F 22MD Usual Residence of Decedent 10d. Inside City Limits any 10c. City, Town or Location . 23a or 28a-f show notified at once. 1 X Yes 2 No 28a-f show MD N/A Baltimore Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
rigury or other traumalic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3600 Kelox Road 21207 Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14 Race - American Indian, Black items 2 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc." White etc. 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Yea 1 Yes 2 X No specify: Specify: Black þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Catonsville Comm. 1 Student College 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glenn Smith, Jr. Angela Lee 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Smith, Jr. 3600 Kelox Road, Baltimore, Md. 21207 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 7/29/2006 Baltimore, Md. Other Spe Donation √5 22. Name and Address of Facility Estep Brothers Funeral Home 1300 Eutaw Place, Baltimore ature of Fun in I Servi 21217 Md eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea Approximate Interva **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a. Saddle pulmonary thromboembolus Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) b. Deep venous thrombosis Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause Leg injury (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical UNPENDED AMENDED Box 68760, he death certificate be e attending phys for use as the b IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknowr detached <u>о</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed death? page 1 🗸 Yes ✓ Yes 2 2 No the Hospital or Attending Physician: thin 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other 7 DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 1 🗸 Yes No 28a Date of Injury Jul 8, 2006 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Driver auto auto collision 1 Natural Division 0305 hrs 1 Yes 2 V No l Director: ed in by the f 5 Pending 2 🗸 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide 24 hours a determined (Specify) Interstate/Express I-83 at mile marker 8.2, Baltimore, MD 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started cal To the I 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License numbei 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. July 24, 2006 30. Name and address of person who completed cause of death (Item 23a) 5 Assistant Medical Examiner Pamela Southall, MD 111 Penn Street, Baltimore, MD 21201

DHMH 17 KeV 1/200 **OCME 2006**

State Registra

31. Date filed (Month, Day, Year)

AUU

Please Type or Print in Black Indelible Ink 06-05459 State of Maryland / Department of Health and Mental Hygiene Barton M Smith 1. For State Certificate of Death Rea. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day July 26, 2006 2152 hrs **Medical Examiner** Smith Barton 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Bon Secours Hospital N/AIf Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Davs Country) MD Director 1 XM 2 50 07/13/1956 213-64-5133 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 X XYes 2 No 28a-f shov Baltimore MD N/Ashould be filed within 72 hours after death with the Maryland and Mental Hygiene 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 28a-f notified at o 21216 U.S.A. 1802 North Dukeland Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 12. Was Decedent Ever in U.S Funeral or items must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1XXNever Married 2 Married $2XX_{No}$ Yes Yes 2X No specify: Specify Black 3 Widowed 4 Divorced If Yes, Give Year Examiner à 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Mechanic Auto Shop is marked other atic event, the Me 18.Mother's Name (First, Middle, 17 Father's Name (First, Middle, Last Be Harriet Smith Joseph Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ ages I and 2 she int of Health and it: If item 27 is other traumati 1802 North Dukeland St., Baltimore, Md.21216 Harriet Smith Mother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Department of Important: injury or oth Memorial Park8/1/2006 Windsor Mill, Md. King Donation 5 Other Spearly ²² Name and Address of Facility ESTEP Brothers Funeral Service 1300 Eutaw Place, Baltimore, M ture of Funeral Service Licens Approximate Interval Between Onset and Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart e disease, o Physician failure. List only one cause on each line /Medical Death Narcotic intoxication associated with meumonia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial - tran Physician/Medical UNPENDED **AMENDED** item#23a,PII,27,28a-f,perME,g858,8/23/06 TI Box 68760 23d Date of delivery IF FEMALE: 23c If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions þ 1 Yes 2 No 3 Probably 4 V Unknown Cocaine use Completed ticate has been si page 2 should b 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? After this certificate has performed? 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 / Inpatient 2 Other₄ Nursing Home 5 Residence 6 Other ER/Outpatient 3 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year Manner of Death 28b. Time of Injury Natural 1 Yes 2 No Pending death. Director: d in by the f Fnd 7/26/2006 Fnd 10:25 am unk 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1802 N. Jutland Street 28e. Place of Injury - At home, farm, street, factory, office building, etc X Could not be 3 Suicide determined found at residence timore, MD Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I and manner stated 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe July 27, 2006 O.C.M.E mi 30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

		-	For State Registrar	State of Ma	aryland.		artment of H		and Me		iene ()	06	24059		
	* = ×		Decedent's Name (First, Middle,	Last)					2	Date of Dea Month	th Day	Yeer	3. Time of Death		
	Physicia /Medic			Elizabeth	D. Sch	aefe:	r				28, 20	06	7:55 A ^M		
	Examin	S	4a. Facility Name (If not institution, g	give street and number)			4b. City, Town, o	r Location of	of Death		4c. Coun	ty of Death			
		200		on Gardens			If Under 1 Year	lockvi		Date of Birth			gomery		
Ш	Funeral			5. Sex 7. Ag 1 ☐ M 2 X ☐ F	ge (In yrs. lasi	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day ctober 2	Year)	Cou	place (State or Foreign ntry)		
Tr S	Director	-	Usual Residence of Decedent		92				U	croper z	9, 1913	wasii.	ington,D.C.		
	/land		10a. State 10b. County		10c. City, T	Town or Lo	ocation						10d. Inside City Limits		
	Man	to	Maryland Mon	tgomery			Cl	nevy (Chase				1 ☐ Yes 2 No		
	or 28	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen o	f What Cou	intry?		
	1h wi		4805 Dru	mmond Avenu	1e			20815					States		
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	?	13.	Was Decedent of his Yes, specify Cub	lispanic Ori an, Mexicar	igin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)		ace - Ameri fack, White,			
36	or It	by Fu	1 Never Married 2 Marne 3 Widowed 4 Divorced	ff Yes, Give	No		1 ☐ Yes 2🌠 No	Specify:			Spec				
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. do other than "natural", or Itama 23a or 28a-f ehow event. It a Medical Evandral must be notified at	q pa	15. Decedent's	Year or Dates:		16a. Dece	dent's Usual Occup	pation			16b. Kind of		White ndustry		
15	in 72 in na	Completed	(Specify only highest	grade completed)		(Give	kind of work done DO NOT use retire	during mos	t of working	,			,		
112	within iene.	шо	Elementary/Secondary (0-12)	College (1-4or	5+)		Home	maker				Own H	Iome		
	illed Hygie other	BeC	17. Father's Name (First, Middle, La	ast)				18. Mothe	er's Name (First, Middle,	Maiden Sum	ame)			
lan	should be and Mental as marked o	To B		Daniel Dood	ly					Brid	get Wa	ırd			
Maryland	s 1 and 2 should be Health and Mental Item 27 is marked other traumatic ev		19a. Informant's Name/Relationshi	р (Туре, Print)		19b. Maili	ing Address (Street	and Numb	er or Rural I	Route Numbe	r, City or Tow	n, State, Zij	p Code)		
	# 2 m		Carl F. Schaef	er/ Son				d Ave					and 20815		
ore	ges 1 ar t of Hea if Item or other		20a. Method of Disposition	3 □Removal from State	20b. Plac	e of Disp	osition (Name of matory or other pla	ce) [Dat .T11 7		20c. Location	1 - City or T	own, State		
Ĕ	Pag ment ant: I	١.,			Cr	emāt	orium Inc		29. 2	2006	Beth	esda,	Maryland ,		
Baltimore,	permit. Pages. Department of t Important: If Ite any injury or ot		21. Signature Funeral Service Licensee 21. Signature Funeral Service Licensee MO0335 MO0335 Cemetery, crematory or other place) MOntgomery Licensee MO0335 MO033												
			23a. Part1. Enter the disease, or	omplications that cause	d the death.	Do not en	ter the mode of dy	ng, such as	cardiac or	respiratory ari	est,		Approximate Interval Between Onset and Death		
	Physician	23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finaf disease or condition Myocardial Infarction													
0	/Medical		resulting in death)		s a conseque		CLIOII			***					
п	Examiner		Conventially list conditions	b		UC.									
r.\$	P tV ≃	ner	Sequentially list conditions, in any, loading to immediate cause. Enter Underlying Cause (Disease or injury		EU;seithup B 8	ngs of):									
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C											
Ö,	oe exe	ũ	1930tting in Oddiny Edot	Due to (or as	s a conseque	nce or,									
8760,	ate b	dicai	'	d						·					
9 ×	requires that the death certificate be executed for signed by the attending physician and the nould be detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outcome	e of pregnanc	ev					23d I	Date of deliv	uerv		
Вох	attendatter	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant a	2 Fetal d	eath 3	□Ectopic pregnand □ Other (specify) _	У				Month	Day Year		
o.	he de	ysic	1 □ Yes 2 🌠 No 9 □ Unknown	9□ Unknown	21 11110 01 000										
Ω.	res that the de signed by the 6 be detached 1	H.	Part II. Other significant condition	s contributing to death	but not result	ing in the	underlying cause gr	ven in Part	I.	23e. Did to	bacco use co	ontribute to	the cause of death?		
ds	uires sign ld be	d b		Deme	ntia					1 🗆 Y	es 2∭ No	3 ☐ Pro	bably 4 Unknown		
Records,	> 0 5	Completed by		Hyperte	onaion					24a. Was		b. Were aut	topsy findings available		
Re	The law ate has b page 2 sl	Ĕ		пуретс	ension					autop perfor	med?	death?	ompletion of cause of		
	rician: Th certificate rector, pag	a	25. Was case referred to medical					26. Plac	e of Death	Check only o	1	1 103	2 140		
Division of Vital	Phyeician: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 ☐ Inpat	tient 2 🗆 El	R/Outpatie	ent 3 DOA Ct	hor		e 5 🗆 Resid		other (Spec	Assisted Living		
0	g Phy er thi		27. Manner of Death	28a. Date of Inj (Month, D	jury 2	28b. Time		iry at	28	Bd. Describe h	low injury occ	:urred			
ion	nding Fath. r: After e funer	atio	1 Natural 5 Pending 2 Accident investig	,	2) / 52.7	,,	M 1	Yes 2□]No						
Vis	Atte	tific	3 Suicide 6 Could n 4 Homicide determine	ned 200. Place of It	njury - At hometc. (Specify)	ne, farm, s	treet, factory, office		28	Bf. Location (S City or Tox		mber or Rui	ral Route Number,		
Ö	rs aft al Din ed in	Certification:	W	4						-	·				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the for	Medical	29a. Certifier 1 Certifying (Check only one)	g Physician: To the bes Examiner: On the basis and manner s	of examination	ledge, dea on and/or i	ath occurred at the t nvestigation, in my	ime, date a opinion, de	nd place, ar ath occurre	nd due to the d d at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)		
	ompl	Me	29b. Signature and title of certifier				29c. Licer	ise number			29d. Date sig	ned (Month	n, Day, Year)		
	F > F 0		Merlen	V/en	nen	AM	us	D35	791		.T11	1v 28	, 2006		
	Øi		30. Name and address of person v	who completed cause of	death (ftem	23a) (Type	e, Print)	ככע				-, 20	, _000		
	10		Merlyn K. Vemu	ry, M.D. 98	301 Geo	orgia	Avenue	227 9	Silver	Sprin	g, Mar	y1and	20902		
N		ate	31. Date filed (Month, Day, Year)	32. Regis	trar's Signatu	ГР	Sparke			-					
	Regist	rar	AUG 0	T 7000	RECARLS &	10.	27								

		•	_ FOF	epartment of Health and Men Certificate of Death	tal Hygiene	2006 26060				
	X		Decedent's Name (First, Middle, Last)		Date of Death Month Day	3. Time of Death				
	Physicia /Medic		Matthew S	alope K o	7 26	2006 1430 M				
*	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death				
			Shady Grove Hospita1 5. Social Security Number 6. Sex 7. Age (In yrs. last bin	Gaithersburg		ontgomery				
	Funeral Director		404 405	Months Days Hours Min. (Date of Birth Month, Day, Year) Dril 4, 19	9. Birthplace (State or Foreign Country) Penn				
	모		Usual Residence of Decedent			10d. Inside City Limits				
	ahov	ō		hersburg		1 ☐ Yes 2 ☐ No				
	28a-f	rect	10e. Street and Number	10f. Zip Code	10g. Citiz	en of What Country?				
	h with	Funeral Director	17741 Stoneridge Drive	20878	Un	ited States				
	death	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No- 1	Race - American Indian, Black, White, etc.				
36	d within 72 hours after death with the Maryland Jien. t than "natural", or iteme 23a or 28a-1 ahow tha Macical Examinar mast be notified at	by Fu	1 ☐ Never Married 2√☐ Married 1 ☐ XYes 2 ☐ No WW ☐ If Yes, Give	1 ☐ Yes 🏋 No Specify:		Specify: White				
21215-0036	tural sal Ex			Decedent's Usual Occupation	16b, Kin	nd of Business/Industry				
215	hin 72 in "ne Medit	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)						
21	DES	Con	8th I	ngineer Custodial		urch				
Maryland	ad la b	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fil						
ž	d 2 should be the and Mental 7 is marked of traumatic ever	2	Frank Salopek 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b	Mailing Address (Street and Number or Rural Ro	Ann Carter Oute Number, City or Town, State, Zip Code)					
Z	d 2 s th ar 7 ts trau			741 Stoneridge Drive,	-					
ore,	of Health item 27 i		20a. Method of Disposition 20b. Place of cemeter	Disposition (Name of y, crematory or other place) July 31,	2006 20c. Loc	cation - City or Town, State				
Ë	Pages ment of thant: If its ury or o		I LX Burial 2 Cremation 3 Hemoval from State	ection Cemetery	Clin	nton, MD				
Baltimore,	permit. Pag Depertment Important: I any injury o		21. Signalure of Funeral Service Licensee		Funeral Home, Inc. 6633 01d					
	40240		23a. Part 1. Enter the disease, or complications that caused the death. Do	Alexandria Ferry Ro		Approximate				
	Dhamisias		shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death				
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence	of):		1 Day				
	Examiner		Sequentially list conditions, b. Cerebrova	v Preumonia scular Acciden	7	3 days				
	B 14 %	iner	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying	of):						
_	sicien end	Examine	Cause (Diseese or injury that initiated events c	of):						
68760	death certificate be executed eattending physicien and and and for use as the burial-transit	caiE	C _d							
.89	rtificate I g physi as the t		15 - F - A - A - A - A - A - A - A - A - A							
Box	leath certifical attending phy I for use as th	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 ☐ Ectopic pregnancy	2	3d. Date of delivery Month Day Year				
	the at	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)						
P.0	that the danger that the danger that the detached		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?				
rds	quires n sign ald be	d by	Atrial Fibrillation Di	alieter Pellitis,	1 Yes 2	No 30 Probably 4 □Unknown				
Records,	The law requires that the tee has been signed by the bage 2 should be detache	Completed	CHT	/	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
Ä		Com			performed? 1 Yes 2 No	death? 1 🗌 Yes 20 No				
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (C						
	ਦ ≑ ਲ	. To	1 Yes 21 No 11 Inpatient 2 EH/OL	tpatient 3 DOA 4 Norsing Home	5 Residence 6 Describe how injury					
ion	nding Phi tth. : After thi e funeral	ation		njury Work? M 1 ☐ Yes 2 ☐ No						
Division	or Attendation death Director:	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office 28f.	Location (Street and City or Town, State)	Number or Rural Route Number,				
۵	urs aft rel Di									
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) (Check o	d/or investigation, in my opinion, death occurred a	it the time, date and	place, and due to the cause(s)				
	To the Within To the	Me	29b. Signature and title of certifier	29c. License number	29d. Date	a signed (Month, Day, Year)				
	•		1	MD 64407	7/3	27/06				
	0		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	0- 0	1 :11 4.~				
101		ile.	31. Date filed (Month, Day, Year) 32. Signature	Medical Center	Ve, Ko	duille MD				
	Sta Registi		AUG 0 1 2006 Braue &	Could						
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DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M	aryland	-	rtment					21	106	24061
			Registrar Decedent's Name (First, Middle,	Last)		001	inoatt	01 2	Jean		2. Date of Dea	Reg. No		3. Time of Death
	Physici			Shiflet	4						O 7	Day	O6	1-30 A M
	/Medic Examin		4a. Facility Name (If not institution.	give street and number)		4b. City,	Town, or	Location of	of Death			nty of Death	
			Perring Parkway	Centur Gen	esis (c/duca	e	Bag.	hour).	Balhoni	
	Funeral Director		5. Social Security Number J 6 225-36-8115	5. Sex 7. A 1 ☐ M 2 🔀 F	ge (In yrs. Ia 73	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Dat 10/28/	h y, Year) 1 932	9. Birthp Court VIRG	lace (State or Foreign try) INIA
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						1	Od. Inside City Limits
	/aryl	ō		TMODE										1 ☐ Yes 2 🔯 No
	28a-	Director	MD BALT 10e. Street and Number	CIMORE	1	PARK	10f. Zip	Code				10g. Citizen	of What Cour	itry?
	3a ol	Ö	1608 TAYLOR AVE	ENUE			2	1234	ł			US	A	
	deatl	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	S. 13. \	Vas Deced	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		Race - Americ	
98	or Ite		1 Never Married 2 XMarrie	d 1 ☐ Yes 2 📉			I □ Yes 2		Specify:		7110411, 0101,			ITE
21215-0036	i within 72 hours atter death with the Maryland liene. r than "naturel", or Items 23a or 28a-f show the Medical Examena must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:		1C+ D	landa Harra	10						
7-	"nat	Completed	15. Decedent's (Specify only highest	grade completed)		16a. Deced (Give life, I	ient's Usua kind of wor DO NOT us	k done d	luring mos.	t of work	ing	160. Kind o	f Business/Ind	dustry
212	iene. r than "	шо	Elementary/Secondary (0-12) 12TH GRADE	College (1-4or	5+)	HOM	EMAKE	R				OWN	HOME	
٦	the state of the s	Bec	17. Father's Name (First, Middle, La	ast)	'				18. Mothe	er's Name	(First, Middle,	Maiden Sun	name)	
Maryland		10 E	RUSSELL PAYNE						M	OLLY	UNAVAI	LABLE		
lar	is 1 and 2 should by Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationshi			-					al Route Numbe	-	wn, State, Zip	Code)
	1 and Health em 27 kther t		LINWOOD E. SHIFL 20a. Method of Disposition	ETT/HUSBAN		1608 ace of Dispo	TAYL		VENU				2 1 234 on - City or To	
ور	0 0		W Burial 2 ☐ Cremation 3		CE	ametery, crer	natory or o	ther plac			4			
Baltimore,	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Special Service Line)21. Signature of Funeral Service Line		MOR	ELAND					/2006	HTLLE	NDALE,	ME, P.A.
Ba	permit. I Departm Importar any inju										VD. TOW			
			23a. Part1. Enter the disease, or c shock, or heart failure. List	omplications that cause	d the death									Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Sin d	Star		then	P	UZI					Onset and Death
	/Medical		resulting in death)	Due to (or a	s a consequ	ience of):	0	10-	0 40					
н	Examiner		Sequentially list conditions,	b										
	Di vis	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequ	ience of):								
_	and and I-tran	хаш	that initiated events resulting in death) Last	c Due to (or a	s a consequ	ience of):								
8760,	cate be executed physician and	icalE			,	,								
9	The law requires that the death certificate be executed ate has been signed by the attending physician and a sage 2 should be detached for use as the burial-transit	edic		d							27770			
Вох	eath certific attending p	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			lEctopic pr	eanancy				23d.	Date of delive	*
	death	sicla	in the past 12 months? 1 Pyes 2 Pro	4☐Pregnant a			Other (sp						Month	Day Year
P.0	at the de d by the a etached	Physician/Med	9 Unknown			die in the co			a ia Dani I		23a Did to	page use s	ontributo to th	ne cause of death?
ŝ	ires thal signed t	by	Part II. Other significant condition Permassini Dis	or reduce	DUL HOL 18SU	nung at ute u	idenying d	ause give	en in ranti.	•	1 🗆 1		/	ably 4 Tunknown
Ö	w require been si should l	etec		.,, -,,							1	I	WW. M. S	
Records,	has l	Completed	AUCUD				-				24a. Was autop perfo		prior to cor death?	psy findings available mpletion of cause of
E		e Co	25. Was case referred to medical						26 Place	of Doat	1 Yes	2 No	1 🗆 Yes	2 2 No
Vital	Physicien: this certific ral director,	0 0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat	ient 2 🗆 I	ER/Outpatier	t 3 DO	Othe			me 5 Resid		Other (Specifi	()
ا م	ding Phy h. After thi funeral	L.	27. Manner of Death	28a. Date of In	ury av Year)	28b. Time of	2	8c. Injury Work			28d. Describe h			
Ö	Attending or death. ector: After by the funer	atic	1 Hatural 5 Pending 2 Accident investiga	ation		,,	М		Yes 2□	No				
Division	or Attendated after death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	288. Place of It	njury - At ho atc. (Specify	me, farm, str	eet, factory	, office			28f. Location (S City or Tox		imber or Rura	I Route Number,
	pitel o		29a, Certifier 1 Certifying	Physician: To the bes	t of my know	wladaa daati		at the tim	a data as	d slaga	and due to the	anuso(s) and		nted
	24 ho Fun etely f	edical		xaminer: On the basis and manners	of examinat									
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier				290	. License	number			29d. Date sig	ned (Month,	Day, Year)
	/- > - 0		1 (1 I had	Kley	mo			7	1295	-		7/	27/06	
	h		30. Name and address of person w	no completed cause of	death (Item	23а) (Туре,	Print)					,		
			6701 Charles 1	Stud Sin	tt 42		al,	7	md_	21	204			
	Sta Regist	ate	31. Date filed (Month, Day, Year) AUG 0 1	2006 32. Be gis	trar's Signal	ture	and!	,						
	riegist	rai	AUG V I	LUUU CAR	100 1	19							·	

			1- State of Maryland / Dep	artment of Health and Mertificate of Death	Reg	ne N2006	24062
	Physici	an	1. Decedent's Name (First, Middle, Last) Wilmoth J. Smith		2. Date of Death Month July 24,	Day 2006 Year	3. Time of Death 9:00 am M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 926 South Belnord Avenue	4b. City, Town, or Location of Death Baltimore	1	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 234-32-2215 1 X M 2 G F 82 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You Sept 24,	9. Birtl Co 1923 Wes	nplace (State or Foreign untry) t Virginia
	ith the Maryland or 28a-f show	ector	Usual Residence of Decedent	e			10d. Inside City Limits 1 Yes 2 □ No
	th with th	Dire	10e. Street and Number 926 South Belnord Avenue	10f. Zip Code 21224	10g	. Citizen of What Co	untry?
980	after dea or Items miner m	by Funeral Director		Was Decedent of Hispanic Origin? (Stiff Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
Maryland 21215-0036	Jwithin 72 hours jiene. r than "natural", tre Modical Exe	Be Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) d Supvr. of Securi	king	b. Kind of Business/	
pue ;	I be filed ntal Hyg ed othe event,	BeC	17. Father's Name (First, Middle, Last) William G. Smith	18. Mother's Nam Zola Fla	ne (First, Middle, Mai		
aryla	2 should and Mer Is mark aumatic	스	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Ru	ral Route Number, C	•	
re, M	1 and Health Bm 27 ther tr	100	20a Method of Disposition 20b. Place of Disp	South New kirk Str		c. Location - City or	
Baltimore,	Pages ment of ent: If its ury or o		14 □ Donation 5 □ Other (Specify) Garriso	, ,	4, 2006 B		
Balt	permit. Depart Import any inj once.			22. Name and Address of FacilitChas 4226 Eastern Avenu	ne. Baltin	ore, MD	c. 21224
8760,	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and in proceed compistely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	23a. Part 1. Enter the disease shock, or heart failure test in the cause of the death. Do not established the shock, or heart failure test in the cause on each line. Immediate Cause (Flat disease or condition fesulting in death) Sequentially list conditions failure, leading to immediate cause. Enter Underlying Cause (Disease or Figure 1) that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	and the second s	or respiratory arrest		Approximate Interval Between Onset and Death O y O y O y
P.O. Box 6	that the death certifics ed by the attending ph detached for use as th	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the DbS TWChve Sleep appel			cco use contribute to	the cause of death?
Division of Vital Records,	The faw requirate has been page 2 should	Completed	Myonic obstructive pul	monay disco	24a. Was an autopsy performe	d? prior to death?	topsy findings available ompletion of cause of 2 No
Vita	/slcien: Th	To Be	25. Was case referred medical examiner? 1 Yes 212No Hospital: 1 Inpatient 2 ER/Outpati	Othor	th (Check only one)	e 6 ∏Other (Spec	ifv)
on of	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	tlon: T	27. Mann of Death 1 atural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at	28d. Describe how		,
Divis	al or Attendi after death. I Director: A d in by the fu	ertifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dering the control of the pass of examination and/or and manner stated.				
	To th Within To th compl	Me	29b. Signature and title of certifier	29c. License number	29d	Date signed (Month	, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Typi	1)36191 p. Print)		7-31-6	71221
	1		Bacher Arin MD. VAM	C 10 N. bree	ne st,	Balton	or
•	Sta Regist		31. Date filed (Month, Day, Year) AUG 0 1 2006 32 Registrar's Signature	المالية			

		1 - For State Registrar	State of N	Maryland / i	•	rtment			d Menta	ıl Hygiei Reg.	2000	5 24063
Physi /Med		Decedent's Name (First, Middle, L.	,	irginia S	ealir	ng			2. Dat Mo	e of Death nth July	^{Day} , 2006	3. Time of Death 5:18 p M
Exam			Blacks School	lhouse Road					Taneytov	wn	4c. County of Dea	Carroll
Funera			Sex 7. / 1 ☐ M 2 ☐ X F	Age (In yrs. last bii 84	* .	If Under Months	Days	If Under 24 H Hours M	lin. (Mo	e of Birth nth, Day, Ye ember 24		rthplace (State or Foreign Country) Maryland
e Marylan 8a-f show	Director	10a. State 10b. County Maryland	Carroll	10c. City, Tow	n or Loca	ation	Ta	neytown				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
th with th	ai Dire	10e. Street and Number 2155 Blacks Schoolh	ouse Road			10f. Zip	Code	2178	7	10g.	Citizen of What C	country? J.S.A.
be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Itame 23e or 28e-f show event, the Madical Exercites in most the confiled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Tyes 2 If Yes, Give Year or Dates	s? ⊒ h xo		as Decede Yes, speci		panic Origin? Mexican, Pu Specify:	(Specify Ye ento Rican, e	s or No- etc.)	14. Race - Am Black, Wh Specify:	
within 72 ho iene. then "natur the Medical	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation rade completed) College (1-40		Decede (Give ki life. Do	ent's Usual and of world O NOT use	k done du e retired)	on ring most of v	working	16b.	Kind of Business	s/Industry at home
	To Be Co	17. Father's Name (First, Middle, Las	rge Tucker							Allie	en <i>Sumame)</i> (unknown)	
_ C _ C L		19a. Informant's Name/Relationship Ms. Sandra Seali		ghter 19b							v or Town, State, wn, Marylan	
Pages 1 nent of Hi ant: if itan		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Speci	(ty)		y, crema	tion (Nama atory or oth hepher	her place)	etery	Date 07/31/2		Location - City or Ellicott (r Town, State City, Maryland
permit. Departr Import		21. Smaller Funeral Service Lice	See	100532	22. 1	Name and	Slack F	uneral He	ome, P. <i>A</i> bia Pike	A. Ellicott C	ity, MD 210	43
Physician /Medica Examine physician and physician and sthe purial-transit	dicai Examiner	23a Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	ine. Is a consequence of a consequence	οη.							
the death certificate y the attending physiched for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2		ctopic pre Other (spe					23d. Date of de Month	livery Day Year
The law requires that the de ale has been signed by the page 2 should be detached	þ	Part ff. Other significant conditions	contributing to death	but not resulting in	the und	lerlying car	use given	in Part I.	23e			o the cause of death?
25 8	Completed								-	. Was an autopsy performed? Yes 2.0 N	prior to death?	utopsy findings available completion of cause of
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Tatural 5 Pending 2 Accident investigation	Hospital: 1 _ Inpat 28a. Date of fri (Month, D			ent 3 DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) of 28c. Injury at 28d. Describe how injury occurred					icity)	
tal or Atters after des	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Ir	njury - At home, fai atc. <i>(Specify)</i>	m, stree	t, factory,	office		28f. Loca City	ation (Street a or Town, Sta	and Number or Ri te)	ural Route Number,
he Hospi n 24 hour he Funer detely fill	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exam	nysicien: To the bes miner: On the basis and manners	of examination and	, death o	occurred at stigation, in	the time, n my opini	date and place ion, death occ	ce, and due curred at the	to the cause(time, date a	s) and manner as nd place, and due	s stated. to the cause(s)
To ti withi To ti	Ž	29b. Signature and title of certifier	form. g				License n	S994	3		ate signed (Mont)	,
\0	tate	30. Name and address of p who who 31. Date filed (Month, Day, Year)	MO 299				nge =	307 (١٤٥٠	nnste	V MO	21157
Regis	trar	αμα Δ 1	2006	wayer St.	13	THE PARTY						

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			For State		State of Ma	ryland	•	tificate			IVIEI		- 0	006	21.06	21
			Registrar 1. Decedent's Name (Firs	t Middle Last)			7	incate	01 0	Calli	2.1	Date of Death	. No	UUU	3. Time of Dea	ath
	Physici	an	T. Decedent's Ivaline (Files		'	, /	1.000	01	9			Month	Day 26	2006	10.00	
	/Medic		4a. Facility Name (If not in		reet and number)	(;	1450		Town, or L	ocation of Death				ounty of Dea		
	Examin	er	600D SAMAN		OSPITAL			BAL	LTIM	ORE				٨	I/A	
***	Funeral		5. Social Security Number	-			st birthday)	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.		Date of Birth (Month, Day, Y	/ear)	9. Bir	thplace (State or Fo	oreign
	Director		245-16-44	04	M 2□F	89	Yrs.				9	uly 11,	191	1	"NC	
	and and		Usual Residence of Dece 10a. State 10b.	County		10c. City,	Town or Loc	ation							10d. Inside City L	imits
	f sho	힏	Ma	NI	A	Bal	bimo.	سسان ۲							1 Yes 2	No
	r 28a	rec	10e. Street and Number	, , ,		6.33		10f. Zip	Code			100	g. Citiza	en of What C	ountry?	
	death with the Maryland ms 23a or 28a-f show frount be rediffed at	Funeral Director	5126 Ar	butus	Aue			6	212	15			1	AEL		
	dear dear	ner	11. Marital Status	1	2. Was Decedent E Armed Forçes?		6. 13. W	Vas Deced Yes, spec	dent of His	panic Origin? (S , Mexican, Puerl	specify to Rica	Yes or No- an, etc.)	14	4. Race - Ame Black, Whi		
0	or it	by Fu	1 Never Married 2 3 Widowed 4 D		1 ☐ Yes 2 N If Yes, Give	0	1	☐ Yes 2	2 No	Specify:			5	Specify:	lack	
500	be lied within 72 hours after death with the Marylar Hygiene. d other then "natural", or items 23a or 28a-1 show event, the Marilcel Examination must be notified at	Q Pe		Decedent's Educ	Year or Dates:		16a. Deced	ent's Usua	al Occupat	tion		16	Sb. Kine	d of Business	Industry	
Ċ	n "na	plet	(Specify on	ly highest grade	completed)		(Give I	kind of wor OO NOT us	rk done di	iring most of wo	rking					
7	d within giene. Ir then "	Completed	Elementary/Secondary	(0-12)	College (1-4or 5-	7	Lat	معدم				,	→	Ussep	h's Hosp	,
פ	be filed tal Hygi d other event,	Bec	17. Father's Name (First,	Middle, Last)						18. Mother's Nar	me (Fi	rst, Middle, Ma	aiden S	iumame)		
		To	Wal+	JASON						Fran				SON		
₩.	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/F	Relatio ship (Typ	e, Print)	WiF	19b. Mailin	g Address	(Street ar	nd Number or Ru	u ra l Ro	oute Number, (City or	Town, State,	Zip Code)	
ص ص	1 and Health Sm 27 Sher to		/VONCU C 20a. Method of Disposition	atheri	Ne'lyson	20b. Pi	ace of Dispos	sition (Nan	ne of	rus Al	Date	Salti	Oc. Loc	ation - City or	Town. State	15
_			1 Burial 2 □ Cre	mation 3 Re	moval from State	_ ce	metery, crem	natory or o	ther place	2/	0.0	100 10	امدما	la: al	111	
altin	iff. Partmer artmer ortent injury		4 Donation 5 21. Signature of Fugeral		9	hin	q Mem	Name an	Lend address	s of Facility Ch	nat	man	Har	CIS F	NATEL HOL	ne
n a	permit. Page Department of Importent: If any injury or once.		Land	1 ON	Mo					erstou		-		timora		1/5
₩			23a. Part1. Enter the dis	ease, or complic	ations that caused	the death						spiratory arres	st,	V ILVIC ! A	Approximate Interval Betwee	00
*	Physician		Immediate Cause (Final disease or condition		CCC DT	r ato	DVE	ALLI	106						Onset and Dear	
	/Medical		resulting in death)	(a.	Due to (or as a		-	1,500								
	Examiner		Sequentially list conditio	ns. b.	SEPS	IS										
	sit ad	lner	if any, leading to immedicause. Enter Underlying Cause (Disease or injury	ate	Due to (or as a	i consequ			. 5	0 0 1	D/A	1				
_	and and il-tran	Examiner	that initiated events resulting in death) Last	c.	OHN of Due to (or as a	a consequ		711	OWI	REXIT	CT	111		_		
9	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	calE														
89	ificate g phys as the							-								
XOR	nt the death certificate by the attending phy tached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent preg	mam	ic. If yes, outcome of	of pregnar		Ectopic pr	regnancy				23	3d. Date of de	. ,	
מ	death	sicla	in the past 12 mont 1 ☐ Yes 2 ☐ No	hs?	4 ☐ Pregnant at			Other (sp				 		Month	Day Year	r
J.	at the 1 by th etach	Phy	9 Unknown	dia:			tale of the at a con-	de Alberta		. in Deat		22a Did taha		o contributo t	o the cause of deat	h2
Ś	res that signed b	Š	Part II. Other significant		NAL D		-	ideriying c	ause give	nın Panı.		1 Tes	_		robably 4 Honki	
0.0	w require been si should b	eted	CND SIL	100 100	1.00	DOCK					-	-	1			
Ç Ç	has b	Completed										24a. Was an autopsy performe	ed?	prior to death?	utopsy findings ava- completion of cause	e of
		e Co	25. Was case referred to	medical						26. Place of De	ath (C	12 Yes 2		1 🗌 Ye	s 2X No	
5	rsicie s cert	To Be	examiner?	-	ospital:	nt 2 🗆 E	ER/Outpatien	t_3 🗆 DC	Othe	p+		5 Residen		Other (Spe	ecify)	
ō	g Phys er this eral dir		27. Manner of Death	7- "	28a. Date of Injur (Month, Day	γ	28b. Time of Injury		28c. Injury Work		· · · · · · · · · · · · · · · · · · ·	Describe how				
0	anding Flath.	atio	2 Accident	Pending investigation	(11011111, 22)	100,	,,	М		es 2□No						
Division of	i or Attenate after deat Director:	Certification:	3 Suicide 6	Could not be determined	28e. Place of Inju- building, etc	ry - At ho c. (Specify	me, farm, stre	eet, factory	y, office		28f.	Location (Stre City or Town,	et and State)	Number or F	lural Route Number,	;
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.			0-461-51						a data and d		al., a - 45-				
	To the Hospital within 24 hours a To the Funeral Completely filled	edical			ician: To the best of er: On the basis of and manner sta	examinat										
	o the	Mec	29b. Signature and title				Λ.	290	c. License						th, Day, Year)	
	->- o		D Tank	the ABO	NGERGI	M	. D.		RE	5000	}	OF	- 5	26-20	006	
			30. Name and address of	of person who co	mpleted cause of d	eath (Item	23a) (Type,	Print)								
	10		MARWAN	ABOU	GER (OI.				HX IT	AN Hes	rT I	MC , B	ML	THUK		
	St Regist	ate	31. Date filed (Month, D.	ay, Year) 1 2006	32. Registra	ar's Signat	ture	20								
10.5	TEGISI	TEIL .	NUC G	1 /11110	F EN DEN OF South	100 ACE.	1 1									

		1	For State Registrar		State	e of Ma	ryland				lealth a Death		ental Hy	giene Reg. No.)	006	21.065
	D		1. Decedent's Name										2. Date of Dea	ath Day	Year	3Time of Death
	Physicia /Medic	al .	Judith M										July	4	12006	1,534 M
	Examin	er	4a. Facility Name (/		.1. 1	- 4	m.	0 1	4b. City	, Town, or	r Location o	of Death	17,000	40.0	ounty of Death	12
			5. Social Security N		6. Sex	7 Age	II (20	ast birthday) If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Birt	th	9. Birth	place (State or Foreign
	Funeral Director		214-72-0		1□M 2		51	Yrs.	Months	Days	Hours	Min.	8. Date of Bird Month, Da 02/23	1955	MD Cou	intry)
		1	Usual Residence of													
	nylan show	_	10a. State	10b. County	Arundel			, Town or L								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ith the Marylar or 28a-f show	octo	MD		Arunder	•	GTE	n Bur		- Codo				10a Citiza	en of What Cou	
	within 72 hours after death with the Maryland ene. then "naturel", or tems 23e or 28e-1 show the Medical Examiner must be notified at	Funeral Director	10e. Street and Nur 713 Marl		oad					p Code L061				USA	BIT OF WITAL COL	indy:
	leath	eral	11. Marital Status		12. Was	Decedent 6	Ever in U.S	S. 13.	Was Dece	edent of H	lispanic Or	igin? (Spec	cify Yes or No lican, etc.)	- 14	4. Race - Amer	
က	or Iter	표	1 Never Marr	ied 2 Marr	ied 1 🗆 Y	d Forces?	to.			. /	an, Mexicai Specify:		(ican, etc.)		Black, White	
93	ours a	d by	3 ☐ Widowed	4 Divorced	Year	or Dates:			1 🗆 Yes	SINO	эрвспу.				Specify: Whi	
5-0	72 h	etec	(Spec	15. Deceden	t's Education st grade comple	ted)		(Giv	edent's Usu e kind of w DO NOT i	ork done	<i>durina</i> mos	st of workin	g		d of Business/li n Insti	ndustry tutions
121	within	Completed	Elementary/Second 12	ondary (0-12)	Colle	ge (1-4or 5	+)		Prod							
d 2	filed Hygie other	ပိ	17. Father's Name	(First, Middle,	Last)						18. Moth	er's Name	(First, Middle,	Maiden S	Sumame)	
a	id be ental ked c	To Be	Vernon '	Vincent	Campbel:	l, Sr.					Mar	y Eliz	abeth	Long		
Maryland 21215-0036	shou and M mar		19a. Informant's N)									Town, State, Z.	ip Code)
Σ	and 2 salth a n 27 le		Ivanhoe	Tucker/	Husband						Road		-		21061	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28a-1 show eny injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Dis 1 Burial 2 4 Donation	Cremation	3 □Removal f	rom State	C	lace of Disp emetery, cre esape:	matory or	other place	tory		ປີພື້1 29 2006		ation - City or 1	own, State Maryland
Balti	permit. Departn Importa eny inju		21. Signature of Fi	uneral Service	Licensee	Mol	443	5	Crema 8717	ed Addre Green	and aft Past	uneral ures I	Alter	native Baltin	es more, Ma	ryland 21286-
6th (8760)	Physician /Medical Examiner bhysician and physician and the prijal-transit the prijal-transit	dical Examiner	Immediate Cause disease or conditive resulting in death) Sequentially list or flam, reading to incause. Enter Unit Cause (Disease of that initiated events)	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as consequence of the cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 22 Pame and Address of Faith (1978) 1979 1979 1979 1979 1979 1979 1979 197												Interval Between Onset and Death
) NC (6	ne deatl the ettr	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									3 - P-		2:	3d. Date of deli Month	very Day Year
ds, P	v requires thet II been signed by should be detec		Part II. Other sign	ificant conditi	ons contributing	to death b	ut not resi	ulting in the	underlying	cause grv	ven in Part	I. 	23e. Did 1	_		the cause of death? obably 4 DUnknown
L. L. T. I. Record	The law requirete has been page 2 should	Completed			0		<u> </u>						24a. Was auto perfo 1 \(\text{Yes}	psy ormed?	24b. Were au prior to death?	topsy findings available completion of cause of
Z Z Z	lcian: Th certificete rector, pag	Be	25. Was case refe examiner?	rred to medica		,				10"	200		Check only			(MO)
1) =	Physicia this cert	2	1 ☐ Yes 2 €		Hospital:	1 Nopation		ER/Outpati 28b. Time		JOA			ne 5 Resi		Other (Spec	city)
	ding Ph h. After th funeral	ro no	1 Natural	5 Pendi	ng igation	Date of Inju (Month, Da	y Year)	Injury		28c. Inju	rk?]Yes 2.[1				
Division	Attendi r death. ctor: A	Certification:	2 Accident 3 Suicide 4 Homicide	6 ☐ Could	not be 28e.	Place of Inj	ury - At ho	ome, farm, s	street, facto	ory, office		- 2	28f. Location (Street and	Number or Ru	ral Route Number,
á	s after s afte	Cert	4 Homicide			building, et	с. (Зреси	y) 					Ony or ro	wii, otato)		
	To the Hospital or Atterwithin 24 hours after de To the Funerel Directo completely filled in by the	edical (29a. Certifier (Check only one)	Certifyi 2 Medical	ng Physician: 1 Examiner: On and	the basis of manner st	f examina	wledge, de tion and/or	ath occurre investigation	ed at the ti on, in my o	me, date a opinion, de	and place, a path occurre	and due to the ed at the time,	cause(s) a date and	and manner as place, and due	stated, to the cause(s)
	To the within To the Comp	×	29b. Signature an	d title of certific	2	mi			2	9c. Licens	+8°	06		29d. Date	signed (Mont)	7.00 &
	10		30. Name and add	tress of persor	who completed	cause of c	death (Iten	n 23a) (Typ	e, Print)	(-0	7	V -	1-10	Y Y	2	M. MI
	,		31. Date filed (Mo	oth Day Year	71777	32. Regist	ar's Sign	ture for	and a	xy/	, 0		91	1	2 V~ 17	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** a M 27, 2006 Terner Ju1y 3:15 Dorothy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospice of Baltimore Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year March 25, Birthplace (State or Foreign Country) 5. Social Security Number Year) **Funeral** Days 1 ☐ M 2 🖾 F Yrs. [′]1933 New 73 York Director 054-24-7268 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir then "naturel", or items 23s or 28s-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director MD Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 8720 Ridge Road 21043 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No II Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify. Š 3 AWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene important: If fem 27 is marked other then any injury or other treumatic event. The Market in the Ma Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albina Botterio Spiro Tingos 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Baylin Daughter 617 Bond Avenue Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet Cem 8/1/2006 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Euneral Service Licensee 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition action) Pnysician murtis JU164 Cancer /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and e burial-transit Due to (or as a consequence of): cal phys the t Physician/Medi IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š Yes 2 No 3 Probably 4 Unknown Completed Deec 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 (2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 DiOther (Specify) NOS ACC Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 図 No ဥ After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1. ■Natural 2 □ Accident 5 Pending 1 TYes 2 No deeth. investigation within 24 hours after deeth To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Fo the Hospital 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) July 27 2006

State Registrar ARON

31. Date filed (Month, Day, Year)

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5-0036

Maryland 2121

Baltimore,

Box 68760,

P.O. I

Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type_Print)

2006

32. Registrar's Signature

Charles

AUG 0

6001 N. Charles St Romanice us 21204

Please Type or Print in Black Indelible Ink 06-05450 State of Maryland / Department of Health and Mental Hygiene 2006 24067 Larry Turner 1- For State Amend #10c PER FH g858 Sectificate 9f Death
1. Decedent's Name (First, Middle, Last) Reg No 2. Date of Death Month Day July 26, 2006 Physician/ 1528 hrs Medical Examiner Turner Larry 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (if not institution, give street and number) **Baltimore City** N/A 5701 Chinquapin Parkway # A Date of Birth(MM/DD/YYYY)Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5 Social Security Number Wash., oreign **Funeral** Hours Min Months Days Country)D.C. 56 02/26/1950 Director 1X M 2 F Yrs 213-54-8098 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Baltimore 1XXYes 2 No Chinquapin Parkway . 23a or 28a-f show notified at once. N/AMd. tours after death with the Maryland 10g Citizen of What Country? Director 10f. Zip Code 10e Street and Number U.S.A. 21239 5701 Chinquapin Parkway 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11 Marital Status Armed Forces? Never Married 1X Yes Specify Black Yes 2XX No specify. 4 X Divorced If Yes, Give Year 3 Widowed the Medical Examiner þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Self Employed 21215-0036 should be filed within and Mental Hygiene 12 Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown If item 27 is marked or other traumatic event, Be Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) ٩ Md.21239 5701 Chinquinpin Pkway, Baltimore, 2 Phillips 3 1 В. Thelma Pages 1 and 2 s ment of Health a 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a, Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State 7/28/2006|Baltimore, Md. Department of Important: I Metro Crematory Donation 5 Other Specify 22. Name and Address of Facility Estep Brothers Funeral Home 1300 Eutaw Place., Baltimore 21. Signature of Fyneral Service Licensee 21217 Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 238-Part I. Enter the disease, or complications that cause Between Onset and **Physician** failure List only one cause on each line Death /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last and Physician/Medical AMENDED UNPENDED e attending physician for use as the burial -The law requires that the death certificate be 23d Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE Year Day 3b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the be detached for 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ð Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? certificate has 2 No ✓ Yes 2 ~ 26. Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: funeral director. Be Nursing Home 5 Residence 6 Other: Scene Other₄ examiner? Hospital: ER/Outpatient 3 Inpatient 2 ✓ Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After Certification: 1 Yes 2 No 1 V Natural Division 5 Pending death the Director: Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suicide (Specify) To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 27, 2006 O.C.M.E. prassell Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State PARAMEN Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 6:20 PM July 27, 2006 Charles Tenen /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sax **Funeral** Months Days Hours 1 🖾 M 2 🗆 F 032-24-7989 74 January 2, 1932 France Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or iteme 23a or 28a-f ehow the Modical Examinar must be notified at 1 ☐ Yes 2 X No Maryland Rockville Montgomery Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5800 Nicholson Lane #1202 20852 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 K Yes 2 □ No 1959-1 Never Married 2 Namied Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates 1963 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Oral&Maxillo_Facial_Surgeon 5+ Dentistry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fit ment of Health and Mental H tant: If item 27 is marked otl Be Isaac Tenen Etia Gendelman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) if Health 5800 Nicholson Lane #1202 Rockville, Maryland 20852 Edith D. Tenen/ Wife 20b. Place of Disposition (Name of compley, crematory or other place)
Montgomery
Crematorium Inc. Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 29, 2006 5 Department of Important: If eny Injury or once. 4 □Donation 5 □ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 M00335 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit uem that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 🗌 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Ce deles 24a. Was an autopsy ibn laken 2 No certificate 1 Yes nonce or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1X Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 2 ER/Outpatient 3 DOA After thi 28c. Injury at Work? 27. Manner of Lath 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \ Homicide within 24 hours after To the Funeral Dire 🔀 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifies 29c. License number Clfilles Zes Zel 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gita Bakshi, M.D. 9406 Old Georgetown Road Bethesda, Maryland 20814

Date filed (Month, Day, Year) 1 2006 32. Figistrar's Signature

AUG 0 1 2006 31. Date filed (Month, Day, Year) 1 2006 State Mark San Registra

ENEN, CHARLES

	1 - For State Registrar	State of Maryland / D	Department of H Certificate of I			iene 2006	- 01000				
nysician	Decedent's Name (First, Middle, Last) Joan	Barbara	Vetr	·i	2. Date of Deat Month July 3	Day Year	3. Time of Dealth 15:15 PM				
Medical xaminer	4a. Facility Name (If not institution, give so 4846 Wright Ave	reet and number)	4b. City, Town, o	rLocation of Death Ltimore	•	4c. County of Deat	h				
neral ector	5. Social Security Number 6. Sex 213-34-0643	M XTF 7. Age (In yrs. last birt	thday) If Under 1 Year Months Days	tf Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 8,	Year) 9. Birt 1936 Mar	hplace (State or Foreign ountry) Cyland				
nd at	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. City, Town	n or Location				10d. Inside City Limits 11√2 Yes 2 ☐ No				
Director	10e. Street and Number 4846 Wright Avenue		10f. Zip Code 212	05	1	0g. Citizen of What Co	ountry?				
aumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director		2. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 1 No If Yes, Give	13. Was Decedent of H tf Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.				
ulcal Exer eted by	3 ☐ Widowed 4 🏋 Divorced 15. Decedent's Educ (Specify only highest grade	Year or Dates:	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	nation during most of work		Specify: Wh					
nt, the Medical is Completed	Elementary/Secondary (0-12) 12 years 17. Father's Name (First, Middle, Last)	Coltege (1-4or 5+)	ssistant Man	•		Convenience	e Store				
matic ever To Be	Michael Kammer	pe. Print) 19b	. Mailing Address (Street	Barbara		; City or Town, State,	Zip Code)				
any injury or other traumatic even any injury or other traumatic even and any injury or other traumatic even and injury or other even and injury or oth	Barbara Kovolenko	daughter 28	315 Graybill Disposition (Name of	Court, N	ew Winds		and 21776				
njury or o	11 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	emoval from State Sacred	ry, crematory or other place Heart Of Mary 22. Name and Addre	Cem. Augus	006	Dundalk,Ma					
any i	23a. Part 1. Enter the disease, or complishook, or heart failure. List only on	Connell	U 7110 Soll	ers Point	Road, I	Dundalk,P.A Dundalk,MD.	21222 Approximate				
ician dical	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each tine. EMPHYS Due to (or as a consequence	EMA				Interval Between Onset and Death				
s the burial-transit	Sequentially tist conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Cause (Disease or Injury that initiated events c.									
be detached for use est by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of de Month	otivery Day Year				
<u>مَ</u> ۾		ntributing to death but not resulting i	in the underlying cause gr	ven in Part I.		bacco use contribute t es 2 □ No 3 □ P					
a 2					24a. Was a autop: perfor	sy prior to med? death?	utopsy findings available completion of cause of s				
Betor a	25. Was case referred to medical examiner?	lospitat:		26. Place of Dear	5.4						
tuneral direction: To	TU THE ZINO	28a. Date of Injury 28b.	Outpatient 3 DOA Sured: 4 Nursing Home 5 Residence 6 Other (Specify) D. Time of Injury M 1 Yes 2 No								
d in by the f	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Vew Nork? 1 Yes 2 No 28c. Injury at Vew Nork? 28c. I										
ely fill	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami one)	sician: To the best of my knowledg ner: On the basis of examination a and manner stated.	nd/or investigation, in my	ime, date and place, opinion, death occur	rred at the time, o	date and place, and du	e to the cause(s)				
To the complet	29b. Signature and title of certifier	VINCEN	RIPPO D	4431	5	8-/-	O &				
6	30. Name and address of person who co	R AVE B	(Type, Print) ATD M1	212	24						
State Registrar	0 1 7111	32/Registrar's Signature	STORAGE!								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #16b Per FH G858 8/01/Gertificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 7:40, **Physician** Dade tranh ames /Medical 4c. County of Death City, Town, or Location of Death Facility Name (If not institution, give street and number Examiner If Under Birthplace (State or Foreign Country) 7. Age (Inlyrs. last birthday) **Funeral** Days Months Hours 244-60+66 Usual Residence of Decedent 1 M 2 ☐ F Director 10d, Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f ehov the Medical Examiner must be notified at Ma 1 Yes 2 □ No Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Items 23a or USA 2. Was Decedent Ever in U.S. Armed Forces? 1 Yes Silvo Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: « ģ 3 Widowed 4 □ Divorced "naturel". Completed 16b. Kind of Business/Ir Fence Work 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) other then College (1-4or 5+) Elementary/Secondary (0-12) Laborer 10 th permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Importent: if Item 27 is marked other th eny Injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be hatherine 0665 Wade James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sister 3412 Park Heights Ava Baltimore Md 21215 crothu 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Fremation 3 Removal from State Greenwort Coneky BALTHER 4 □ Donation 5 □ Other (Specify) thus Nino 21. Signature Fineral Service Licensee 22. Name and Address of Facility Bolhair Med 2/211 Joh Part 1 Enter the gisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cardise on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sicien end e burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical phys. the b attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 DEctopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ Records. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform cete has t 1 🗆 Yes 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director; After th completely filled in by the funeral 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide 10 Contitying Physician: To the best of my knowledge, feeth occurred at the time, data and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier idheer completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

State Registrar 31. Date filed (Month, Day, Year)

AUG 0 1 2006

32/Registral's signature

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		-	For State Registrar	State of Maryland /	Certificate of		Reg. No	4000	24071
			Hegistrar Decedent's Name (First, Middle, Last)		00/11/10410 0/		2. Date of Death	1.	3. Time of Death
5	Physicia	an	HENRY	WILLI	5		JULY 2		730 PM
	/Medic	1.00	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, o	r Location of Death	40	. County of Death	
		4	BALTIMORE REHABILI	TATION EXTENDED	CARE BA	LTIMORE		N/2	
	Funeral Director		5. Social Security Number 6. Sec 229-22-4981	7. Age (In yrs. last t	birthday) If Under 1 Year Months Days	Hours Min.	Mar 15;	9. Birth Cou	place (State or Foreign intry)
	and	1	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
	Manyl f eho	ō	MA N/A	B	altimore			:	1 Yes 2 □ No
	r 28a	rec	10e. Street and Number		10f. Zip Code		10g. Ci	itizen of What Cou	intry?
	th with	Funeral Director	6934 Donach	ic Rd Apt E	212	39			1SA
	r dea	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of F If Yes, specify Cubi	lispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White	ican Indian, , etc.
36	rs afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Nes 2 No If Yes, Give Year or Dates: NW II	1 ☐ Yes 2 No	Specify:		Specify: 2	lack
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "naturel", or iteme 23a or 28a-f ehow event, the Madical Examinar most be notified at		15. Decedent's Edu	cation 16	6a. Decedent's Usual Occup	pation	16b. h	(ind of Business/Ir	ndustry
215	within 72 ene. than "na	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of working d))	
2	filed wil Hygien other th	Con		4405	Engineer	-	(T) . A (C) . H . A (C) . H	MUSTE	_
Maryland		Be	17. Father's Name (First, Middle, Last)	10			(First, Middle, Maidel	1 Sumame)	
Z S	should nd Mer mark	2	Arthur Will 19a. Informant's Name/Relationship (Ty		9b. Mailing Address (Street	And Number or Bural		or Town, State, Zi	ip Code)
Ma	s 1 and 2 should f Health and Mer item 27 le marke other traumatic		Terrelle War	(Vaughbe		120 Rd		J. 1 0 1111, 0 14110, 21	<i>p</i> 0000,
re,	s 1 ar f Hea item other	1	20a. Method of Disposition	20b. Place	of Disposition (Name of otery, crematory or other pla	Da	te 20c. L	ocation - City or T	own, State
Ę	Pages ment of tant: If it	1	1 Surial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	ison VA Cen	8/1/	106 DW	ings Mil	115 Md
Baltimore,	permit. Departm Departm Importa any inju		21. Signature of Funeral Service Licens		22. Name and Addre	ess of Facility Ch	utman	Harris F	uneray home
0	20 E # 9		- eroy H	arris	5240 Pel			Himore	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. D ne cause on each line.	to not enter the mode of dyn	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a CARCINOMA		ING			1 MONTH
	/Medical Examiner			Due to (or as a consequence	ce of):				
Д		ē	Sequentially list conditions,	b. — Due to (or as a consequence	00 UI):				
V	outed id ansit	Examiner	Tany, leads y to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c					
o o	ite be executed sysician and ne burial-transit	Ex	resulting in death) Last	Due to (or as a consequence	ce of):				
8760,	ate by	dical		d		<u> </u>		-	
x 68	n certificate anding phy use as the	/Med	IF FEMALE:	23c, If yes, outcome of pregnancy				22d Date of dolla	
Box	atten for u	cian	in the past 12 months?	1 Live birth 2 Fetal dea 4 Pregnant at time of death	ath 3 ☐ Ectopic pregnanc	у		23d. Date of deliver Month	Day Year
0	at the de by the a tached	Physician/M	1 Yes 2 No 9 Unknown	9□ Unknown					
ds, P	as tha	ρ	Part II. Other significant conditions co	1	g in the underlying cause gr	ven in Part I.	23e. Did tobacco		the cause of death?
Records,	w require been si should t	Completed	CARCINOMA	OF PRO	STATE		24a. Was an		topsy findings available
Re	The lay	dmo	C/11-0[/70/11/			···	autopsy performed?	prior to o	ompletion of cause of
Vital	icien: T certificat rector, pa	0	25. Was case referred to medical			26. Place of Death	(Check only one)) 10165	21ANo
ţ <	ysici	ToB	examiner? 1 🗆 Yes 2 💢 No	Hospital: 1 Inpatient 2 ER/	/Outpatient 3 DOA Ott	her: 4 Nursing Hom	e 5 Residence	6 Other (Spec	uty)
n of	ding Ph h. After th funeral		27. Manner of Death 1 SNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	' '	rk?	8d. Describe how inju	ary occurred	
sio	uttendii death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	D. Di		Yes 2 □No	Of Lagation (Staget	and Mismbas as Dis	
Division	al or Att	Certification;	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	i, farm, str <i>ee</i> t, factory, office	21	Bf. Location (Street a City or Town, Stai		rai Houte Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical C		rsician: To the best of my knowled iner: On the basis of examination and manner stated.					
	within To the compl	Me	29b. Signature and title of certifier		29c. Licens			ate signed (Month	
			1 Tomi	en mo	\mathcal{D}	30272	Ju	LY 25	-, 2006
	0/		30. Name and address of person who c	ompleted cause of death (Item 23	Ba) (Type, Print)				
	4		THOMAS S. MILLET	2 MO 3400 LOCH	KAVEN BOUL	EVALUD,	BATIMOR	E, IVID	21218
	Sta Regist		ALIC 0 1 2	32. Registrar's Signature	1 posts				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yeer **Physician** Helen Witt July 24, 11"30 AM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Genesis Heritage Dunda1k Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🛱 F Oct 20, Yrs. 1923 82 Pennsylvania 190-16-1796 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other then "naturel; or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinational be notified at once. 10a. State 10b. County 1 ☐ Yes 2√ No Director MD Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 USA 7232 Germanhill Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Parson Merle Dillman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Dillman/brother 505 South Wayne Street Lewistown, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition JUly 31, 1 Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 2006 Dundalk, MD. 4 ☐ Donation 5 M Other (Specify) in state State Anatomy Board 655 W.]

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Approximate Intervat Between Onset and Death **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 2 Fetal death 3 Ectopic pregnancy signed by the ette 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown certificate has been sirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 TYes To the Hospital or Attending Physicien: : After this certific s funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Datural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death | Director: / d in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Jonth, Day, Year) 29b. Signature and title of certifier cause of death (Item 3a) (Type, Print) 32. Date filed (Vonth, Day, Year) Registrar's Signature State AUG 0 1 2006 Registrar

			For State Registrar	•	partment of Health and Mertificate of Death	•	giene Reg. No. 2	06	24073
	Physicia /Medic		1. Decedent's Name (First, Middle, Las HENRY	st)	WICKMAN	2. Date of De. Month JULY	Day 28 :	Year 2006	3. Time of Death 12-250 A M
	Examin		5 Social Security Number 6. S	AVVIEW MEDICAL CENTE	av) If Under 1 Year If Under 24 Hrs.		4c. County	VA	lace (State or Foreign
	Funeral Director		319-10-2010 1 Usual Residence of Decedent	DM 2□ F 79 Yrs	Months Days Hours Min.	8. Date of Bird (Month, Da	1926		lace (State or Foreign
	he Marylar 18a-f ehow	Director	10a. State 10b. County	10c. City, Town or	BALTIMORE		10g. Citizen of		0d. Inside City Limits 12 19s 2 □ No
	h with t	i Dir	10e. Street and Number 1425 BANK	ST	10f. Zip Code 2 / 23/		-	SA.	•
200	be filed within 72 hours after death with the Maryland to Hygiene. A chart than "natural", or Items 23e or 28e-(show event, the Medical Examinar must be indiffied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2	Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify:	pecify Yes or No p Rican, etc.)	- 14. Rad Bla Specif	ck, White, o	
20-0121	within 72 hou ane. than "nature he Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ide completed) (G	seeden!'s Usual Occupation live kind of work done during most of work e. DO NOT use retired) BRICK LAYER	king	16b. Kind of B	. 44	•
ומונת ל	should be filed within nd Mental Hygisne. marked other than imatic event, the M	To Be Co	17. Father's Name (First, Middle, Last)		18. Mother's Nam	ne (First, Middle,	Maiden Sumar	-	
Mai	permit. Pages 1 and 2 should Department of Health and Men Important: If Itam 27 is marke any Injury or other traumatic ones.		19a. Informant's Name/Relationship (ailing Address (Street and Number or Ru 6.5. Ellwood Ave	1 11		State, Zip	4
ָר מ	of Heal of Heal fitsm 2 r other		20a. Method of Disposition → □ Burial 2 □ Cremation 3 □	20b. Place of Di	sposition (Name of	Date	20c. Location	- City or To	wn, Slate
	permit. Pages Department of Important: If It any Injury or o		4 Donation 5 Other (Specification)	V) Holly &	Vills Cem. 7/3	3//06	MADLE	Rive	r, MD
מ	permit. Departr Imports any Inj		Vaul-M.	stella	22. Name and Address of Facility PAUL STELLA FUNETA 7527 harford RO. 1	3 A Ito M	0 21234	<i>(</i>	
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a VENTRICULAR TA	CHYCARDIA	or respiratory a	rrest,		Approximate Interval Between Onset and Death HOURS
	Examiner		Sequentially list conditions	Due to (or as a consequence of): SPINAL SHOCK					2 DAYS
,	executed in and in ital-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in dealh) Last	c. ABDOMINAL ADPL Due to (or as a consequence of):	tic Aneursym				5 years
00/00	ntificate be ng physicie s as the bur	Medical	IF FEMALE:	d					
.c. po	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending physician and K completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown -	3 Ectopic pregnancy 5 Other (specify)			ite of delive onth	ny Day Year
cords, r	equires that en signed b ould be deta	by	_	contributing to death but not resulting in the			obacco use con Yes 2 No		ably 4 Unknown
משבו ש	: The law r icete hes be ; page 2 sh	Completed	Dispase			24a. Was autor perfo 1 \(\text{Yes} \)	psy ormed?	Were aulo prior to cor death? 1 \(\text{Yes}	psy findings available inpletion of cause of 2 No
VII	ysiclan is certifi director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗶 No	Hospital: 1 Minpatient 2 ☐ ER/Outpa	26. Place of Dea atient 3 □ DOA Other: 4 □ Nursing H	ith <i>(Check only d</i> lome 5 ☐ Resi		ner (Specify	·)
DIVISION OF	tending Ph leath. tor: After th the funeral	Certification: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be		M 1 Yes 2 No		how injury occur		
	s after or At at Direct of	Certif	4 Homicide determined		, street, ractory, office	City or To	wn, State)	Der or Hura	I Route Number,
	the Hospit in 24 hour the Funan pletely filts	Medical	(Check only 2 Medical Examone)	nysician: To the best of my knowledge, d miner: On the basis of examination and/o and manner stated.	or investigation, in my opinion, death occu		date and place,	and due to	the cause(s)
	To T Com	2	29b. Signature and tille of certifier	2 PMD	29c. License number RES←000		29d. Dale signe TULY 2		
	b		MICHAEL AWAD, JOI	completed cause of death (Item 23a) (Ty	ppe, Print) L, 600 NOLTH WOLFE				
	Sta Regist		31. Date filed (Month, Day, Year) AUG 0 1 2006	32. Registrar's Signature	W				

1- Registra Amend #2 Per phytate of Many Any Department of Health and Mental Hygiene Registra Amend Item #25 Per Phy G857 79 Itificate pof Death Reg. No. Reg. No. 2. Date of Death July 22, 2006 Month Day Year 3. Time of Death 1. Decedent's Name (First, Middle, Last) Ward **Physician** eanet 200) /Medical Sounty of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1 Conter TIMORE S Hospita Ka orthwest ud If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months ry) 1□M 2XF 64 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 X Yes 2 □ No Baltimore Director WD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Therle Dr. Apt 102

12. Was Decedent Ever in U.S.
Armed Forces? 21215 U.SA 00 by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Health and Mental Hygiene. Important; if item 27 is marked other than "naturel", or item any injury or other traumatic event, the Medical Experiment. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) xultimore City Baitimore Citi Elementary/Secondary (0-12) College (1-4or 5+) Parent Liasan 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Waylie mozell Errin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Phyllis Brooks/Daughter landallstam MU 4205 Star Cr 01133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

↑

Burial 2 □ Cremation 3 □ Removal from State

4 □ Donation 5 □ Other (Specify) 7/28/06 me merial Valighin C. Greene Juntal service 21, Signature of Funeral Service Licensee 22. Name 8728 Liberty Rd Randalistan mo 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscleron iovascular Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine been signed by the attending physicien end should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has t director, page 2 s autopsy performed 1 Yes 2 No 1 Yes 25 No To the Hospitel or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XX No 1 Inpatient 2 X ER/Outpatient 3 □ DOA Certification: To ctor: After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours of To the Funaral 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2006 Name and address of person who completed cause of death (Item 23a) (Type, Print) old my 5401 ton atricia 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 10 10 6 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year Physician Wetzelberaer (大 8:40 AM 3000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Parkville, mi Vak. rest If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Jan. 3, 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2X)F 214-18-6775 84 Germany Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits worle 10a. State r then "natural", or iteme 23a or 28e-f ehov The Medical Examiner must be notified at 1 Yes 2 No Director Baltimore Co. Parkville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8810 Walter Blvd. United States filed within 72 hours after death Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □ Yes 🛣 No White Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygle, Important: if item 27 is marked othar th eny injury or other traumatic event. The SINCE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mielke George Helen UnKnown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10321 Malcolm Circle Apt. C Cockeysville, MD 21030 Mr. John N. Wetzelberger, III / Son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State July 31,2006 Baltimore, Maryland Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility 1050 York Rd. Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Dulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequence of): Be Completed by Physician/Medical Examiner physician and s the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 2□ No 1 ☐ Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 ☐ Yes 2 🖫 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Urursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Injury To the prospect within 24 hours after death.

To the Funeral Director: Al death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aren

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

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32. Resistrar's Signatu

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		4	For State Registrar	State of M	Marylan	-	artment o			Mental H	lygien Reg. N	$Z \coprod U$	6	240	76
4	N. 7	34	Decedent's Name (First, Middle, La	ist)						2. Date of	Death		V	3. Time of	Death
	Physici /Medic		Cheng-Tsa	i	1	Wen				July	27,	^{1y} 2006	Year	7:15	АМ
	Examin		4a. Facility Name (If not institution, gi	ve street and number	er)		4b. City, To	wn, or Loc	cation of Dea	th	40	c. County o	f Death		
20			13401 Valley Dr	ive			Rock	vill			M	lontgo	mery	7	
	Funeral			Sex 7 1 X M 2 □ F		ast birthday)	If Under 1 \ Months D		Under 24 Hrs lours Min	(Month,	Day, Year)	9. Birthp	lace (State o	r Foreign
1	Director		247-96-2343	Z 201	75	Yrs.				Sept. 2	23 , 19	30	Chir	na	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10	0d. Inside Ci	ty Limits
	Mary	ō	Maryland Montgome	5 7		D 1 17								1 🗆 Yes	2X No
	28a	rec	10e. Street and Number	L.y		Rockvil.	10f. Zip Co	de			10g. C	itizen of W	hat Coun	try?	
	3a o	Funeral Director	13401 Valley Drive				208	50			Ubit	ed Stat	toc		
	deatl	Jer	11. Marital Status	12. Was Decede		S. 13.			nic Origin? (Specify Yes or to Rican, etc.)		14. Race	- Americ		
9	or Ite	Ē	1 ☐ Never Married 2 🙀 Married	Armed Force 1 Tes 2 If Yes, Give			rres, specify 1 ☐ Yes 2 %		pecify: C				, White,		
21215-0036	within 72 hours after death with the Maryland ane then "natural", or iteme 23a or 28a-f ehow ta Madisal Examinar must be notitied at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date	s:		103 24	1140 5	pocity. C	un lese		Specify:	ASIA	L I	
5	72 h	Completed	15. Decedent's E (Specify only highest g	ducation ade completed)		(Give	dent's Usual C kind of work of	tone durir	n ng most of wo	orking	16b. l	Kind of Bus	iness/Ind	dustry	
121	Mithin Den	d L	Elementary/Secondary (0-12)	College (1-4d	or 5+)		rical En	,			Com	ata sata	: ~ C	*******	
	Hygie Hygie ther I		17. Father's Name (First, Middle, Las			шесь	LICAL III	<u> </u>		me (First, Mide		struct		Julearia	
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. If item 27 is marked other then "natural", or iteme 23a or 28a-f ehow or other traumatic event, the Madical Examinar must be routled at	To Be		vail <i>a</i> ble					Not	Availabl		, oamana			
a	2 sho and Is m		19a. Informant's Name/Relationship	(Type, Print)						ural Route Nur			State, Zip	Code)	
	and lealth m 27		Betty H. Wen/Wife		201 0					Lle, Mary					
O.	ges 1 t of H if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	Removal from Sta		emetery, crer	sition (Name natory or othe	r place)	200	ust 2,		ocation - (
ţ	tmen tant:		4 □Donation 5 □ Other (Spec		PO	-	Cremato					thesda			
Baltimore,	permit. Pages 1 and 2 Depertment of Health s Important: If item 27 li any Injury or other tra <u>905e.</u>		21. Signature of Funeral Service Lice	eller.	0092	Ro	Name and Ackville,	Inc.	Facility I 300 West	Robert A. Montgon	Pund ery Av	nrey Fi venue,	nera Rocki	l Hame Ville, N	MD
50,	Physician and Medical Examiner Reas as the burial-transit	l Examiner	23a. Part1. Enter the disease, or corshock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Mycco Due to (or b. Lype Due to (or	andial as a consequent as a consequent as a consequent	Infarct: uence of):	ian							Approximate Interval Bet Onset and t	ween
P.O. Box 68760,	equires that the death certificate be executed sen signed by the attending physician and iculd be detached for use as the buriat-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknown	2 ☐ Feta t at time of d	Idéath 3 eath 5	Ectopic pregi	fy)			_	23d. Date Mon	th	Ďay 1	Year
	res th signed be di	b	Part II, Other significant conditions	contributing to deat	h but not res	ulting in the u	nderlying cau	se given ir	n Part I.					e cause of d	
orc		eted									☐ Yes 2	- K-140	3 7100	ably 4 📑	JIKNOWN
Division of Vital Records,	e la has	ompie								24a. W au pe 1 ☐ Ye	itopsy irformed?	pi de	nor to coreath?	psy findings and pletion of call	available ause of
ital	ician: Th certificate rector, pag	0	25. Was case referred to medical					26	S. Place of De	ath (Check on		0 1		26110	
f V	ding Physician: h. After this certific funeral director,	To B	examiner? 1 ½ Yes 2 □ No	Hospital: 1 Inp	atient 2	ER/Outpatier	nt 3□ DOA	Other:	4 Nursing	Home 51€R	esidence	6 Othe	r (Specify	<i>'</i>)	
0	ng Pt ter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time o	28c	Injury at Work?		28d. Descrit	e how inj	ury occurre	d		
<u>Ö</u>	Attanding r death. ector: Atter	atic	2 Accident investigati	on			М		2 🗌 No						
Divis	al or Att s after de l Directe id in by t	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place of	Injury - At he etc. (Specif	ome, farm, str	reet, factory, o	ffice			n (Street a Town, Sta		r or Rura	i Route Num	ber,
	To the Hospital or Attandit within 24 hours after death. To the Funeral Director: All completely filled in by the fu	edicai C	29a. Certifier 1 Certifying F (Check only 2 Medical Ext one)	hysician: To the beaminer: On the basi and manner	s of examina	wledge, deat tion and/or in	h occurred at vestigation, in	the time, my opini	date and place on, death occ	e, and due to t urred at the tim	he cause(ne, date ar	s) and man	ner as st	ated. the cause(s	;)
	To th withir To th comp	Me	29b. Signature and title of certifier		2		29c. L	icense nu	ımbər		29d. D	ate signed	(Month, i	Day, Year)	
			1 /m	-		200		D0050	209		July	27, 2	2006		
-	12		30. Name and address of person wh	completed cause	of death (Iten	n 23a) (Type,	Print)								
7.5	10		Brian Shen, M.D. 50					g, Ma	ryland	20877					
	Sta Regist		31. Date filed (Month, Day, Year) AIIG 0 1	2006	istrar's Signa	iture	parte								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Eg. 2006 JOHN JAMES WIGHT 12:02 PM /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours Min 1 → M 2 □ F Yrs. 220-03-2446 VIŔGINIA Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "naturel", or Items 23a or 28a-f show the Madical Examinar must be notified at 1 ☐ Yes 2X No Director ROSEDALE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? APT. 2C 21237 USA 15 PAULA PLACE death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 □XYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: <u>ج</u> 3 ☐ Widowed 4 ☐ Divorced WHITE eted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry at Hygiene. Compi Elementary/Secondary (0-12) College (1-4or 5+) 8TH GRADE DRIVER BALTIMORE SUN permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Hujury or other treumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN WIGHT EDNA BULL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSLYN WIGHT/WIFE 15 PAULA PLACE APT. 2C BALTIMORE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY, INC. 8/13/2006 | Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and sthe burial-transit death certificate be executed ISCHEMIC CARDIOMYOPATHY Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? detached for Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 page 2 should be 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? was autopsy performed? certificete 1 Yes 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 86 26. Place of Death (Check only one) Hospital: 1 K Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2X No 2 ER/Outpatient 3 DOA Sici 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. 1 Yes 2 No investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funerel I completely filled 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mella M.O D 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 JOGINDER P. MEHTA. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

2005

06-05528 William John Yox

Please Type or Print in Black Indelible Ink

Maryland / Department of Health and Mental Hygiene

viiliam John Yox		State of Maryland / Department of Health and Mental Hygiene - For State Certificate of Death Reg No. 2 1 5 7 7 7 7 7 7 7 7 7
Physician Medical Examina	1/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
Medical Examine		4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
harmon .		Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or
Funeral Director		213-70-4916 1 Months Days Hours Min. May 23, 1967 Foreign Country) MD Usual Residence of Decedent
, any		10a. State 10b. County 10c. City, Town or Location 10d Inside City Limit
Maryland 28a-f slrow d at once.	į.	MD HARFORD Jarrettsville 1 Yes 2 XN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
ith the Maryland 23a or 28a-f sho notified at once	o l	2815 Rocks Road 21084 USA
r death wi	Fune	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No
ours aft	g g	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired)
5-0036 led within 72 hours afte Hygiene right than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th Manager Heidtman Steel
21215-0036 uld be filed within 7 Mental Hygiene. warked other than e event. the Medica		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Bernhardt
21215 21216	To Be	John W. Yox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD and 2 sho alth and m 27 is aumati		Dawn Yox /wife 69 West Burce Road Fawn Grove PA 20a Method of Disposition Date 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
≒ ≈ ≈ = =	- 1	1 X Burial 2 Cremation 3 Removal from State Holy Cross Cemetery 8/2/06 Glen Burnie MD
Baltimo permit Page Department of Important: injury or oth	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD
ய ஆ் ் ⊒ .≘ Physician	1	Connelly Funeral Home of Essex 21221 23a Part I. Enter the disease, or fomplications that caused the efaith. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Intervention
/Medical		failure. List only one cade on each line. Immediate Cause (Final disease a. Narcotic intoxication Death
	1	or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):
	ine	sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause
ed nsit	Examiner	events resulting in death) Last Due to (or as a consequence of):
	Medical	x unpended item#23a,27,28a-f,perME,g858,8/14/06 TT
3760, ficate be g physici	/Me	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
Box 687 eath certifice the attending pod for use as the	Physician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
O. Bo at the de 11 by the tached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
S, P.	ed b)	1 Yes 2 No 3 Probably 4 V Unknown 24a Was an 24b Were autopsy findings availab
cords,	Completed by	autopsy prior to completion of cause of performed? death?
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical 26. Place of Death (Check only one)
Vita	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other A Nursing Home 5 Residence 6 Other
of of ording Ply. the transfer to e funeral	 O	27. Manner of Death 1 Natural 5 Pending Fnd 7/29/2006 Fnd 0313 28a. Date of Injury (Month, Day, Year) Fnd 7/29/2006 Fnd 0313 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 x No unk
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it is after death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 X Could not be determined 6 Accident Suicide 1 Accident Investigation Investi
hou hou		4 Homicide (Specify) At name Jarretsville, MD
o the H ithin 24 o the F	Medical	Check only 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
F 3 F 3	Me	29b. Signature and title of certified 29c. License number 29d Date signed (Month, Day, Year)
		O.C.M.E. July 29, 2006 30. Name and address of person who completed cause of death (Item 23a)
		David Fowler M.D. Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201
Sta Registr		31 Date filed (Month, Day, Year) 32 Registrar's Signature
DHMH 17 Rev 1/20		ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month Year **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner non Il Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. VU 6 5. Social Security Number 8. Date of Birth (Month. Day. Year) 12/03/1927 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 78 Months 1. 2 M 2 □ F PA 165-22-2748 **Director** Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 28e-f show other treumetic event, if a McClical Examiner must be nutified at 1 Yes 2 No MD Lutherville Timonium Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21093 USA 2231 Chapel Valley Lane Items 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. and 1 fiem 27 is marked other then "natural", or Items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1. Armed Forces? 1. Armed Forces? 1. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Il Yes, Give Year or Dates 946 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Road Construction Elementary/Secondary (0-12) College (1-4or 5+) Engineering Operator 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Norman Richard Yutzy Bertha May Crise ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alice Yutzy/Wife 2231 Chapel Valley Lane Lutherville Timonium, MD 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Aug 1 20c. Location - City or Town, State Department of H Importent: If ite eny injury or ot once. 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory Inc. 2006 ^ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final spirator **Physician** disease or condition resulting in death) /Medical Due to (or as a c nsequence of) Examiner (4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transit Ja pue The law requires that the death certificate be executed Due to (or as a consequence ol): Box 68760. physician Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Por 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a 9□ Unknown s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ Division of Vital Records. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy perform 2□ No certificate 1 Tes 1 🗆 Yes the Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٢ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA this Date of Injury (Month, Day Year) 28b. Time ol 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 No investigation hours after death. Director: 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a (specifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 Dovis CYOW

31. Date filed (Month, Day, Year) 32. Aegistrar's Signature AUG 0 1 2006 Registrar

		1	For Amend #8 per Registrar	State of A	1apylan 3 8/04	706 Depa	rtment of H	ealth and M Death	lental Hyç	giene Reg. No.	06	24080
			I. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic	_	Robert Livingston	Young					July	25,	2006	12:20 PM
	Examin		a. Facility Name (If not institution, give		r)		4b. City, Town, or Bethe	Location of Death		4c. Count	y of Death atgom	erv
			Carrage Hill Beth S. Social Security Number 6. Sec		Age (In vrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	~~	place (State or Foreign
	Funeral Director		579~38 ~ 0044	M 2□F	86	Yrs.	Months Days	Hours Min.	(Month, Day	, 1920		ington D.C.
	0	-	Usual Residence of Decedent		100 Cit	y, Town or Lo	ncation		Jun 9,1	920	1	Od. Inside City Limits
	show	. 1	Maryland Montgon	nerv	Toc. Cit	Beth						1 ☐ Yes 2 ☑ No
	28a-f	ect	10e. Street and Number	J			101. Zip Code			10g. Citizen of	What Cour	ntry?
:	3a or		4313 Rosedale Ave	nue			20814			Unite	d Sta	tes
	death	Funeral Director	11. Marital Status	12. Was Decede Armed Force	nt Ever in U	.S. 13.	Was Decedent of H	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)		ce - America ck, White,	
0	or ite	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2{ If Yes, Give Year or Date	77	rld r II	1 ☐ Yes 2 █ No	Specify:		Speci	v: Whi	Ite
0500-C	within 72 hours after death with the Maryland ene. Than "natural", or items 23e or 28e-f show the Medical Exertical terrollitied at		15. Decedent's Edu	cation	5. 770.2	16a Dece	dent's Usual Occup	ation		16b. Kind of E	Business/In	dustry
<u> </u>	hin 72 n. n. "ne Medic	plet	(Specify only highest grad	e completed) College (1-4)	or 5+)		kind of work done of DO NOT use retired		(mg	Tolen	20110	Company
7	ad with	Completed		4		Divis	ion Manag	18. Mother's Nam	o (First Middle			Company
yland	be file	Be	17. Father's Name (First, Middle, Last) Herbert Snodgrass						Young	Maloon Coma		
3	hould d Mer marke matic	2	19a. Informant's Name/Relationship (T)			19b. Maili	ng Address (Street			er, City or Town	n, State, Zip	o Code)
<u>8</u>	od 2 s ith an 27 is r traus		Barbara H. Young				Rosedale					
ē,	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show them 7 is marked other than "natural", or items 23a or 28a-f show other traumatic event. If a Medical Exa it at trivial the notified at	Ì	20a. Method of Disposition	2		Place of Disponentery, cre	osition (Name of matory or other place		Date 28,	20c. Location		
Ē	Page nent o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify)		Mo	ntgomery	Crematoriu	m ⊥2006			-	Maryland
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ott		21. Signature of Funeral Service License	989	MO1	433	2. Name and Addre ethesda-(ethesda,	ss of FacilityRob Thevy Cha Mary1and	ert A. 1 20814	7557 W	y Fun iscon	eral Home/ sin Avnune
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cau	sed the deal	th. Do not en	ter the mode of dyir	ig, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition			c Lung	; Liver ar	ad Bone D	isease			Chisti and Dount
	/Medical Examiner		resulting in death)		as a consec		Cannon					
		<u></u>	Sequentially list conditions, if any, leading to immediate	b	as a consec		Cancer					
	I Si Ad de	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
ó	te be executed ysician and burial-transit		resulting in death) Last	Due to (or	as a conse	quence of):						
3760		icai	(d							-	
39 20	in i	Completed by Physician/Med	IF FEMALE:	23c. If yes, outco	me of predo	ancv				23d F	ate of deliv	/erv
.O. Box	that the death cer ed by the attendin detached for use	cian	in the past 12 months?	1 ☐ Live birt 4 ☐ Pregnar	h 2 ☐ Fet	al death 3	□Ectopic pregnanc □ Other (specify) _	У			Month	Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow	'n							
ري ص	s that ined b e deta	y Pl	Part II. Other significant conditions of					ven in Part I.				the cause of death?
ž	w requires that been signed to should be det	ted	Hypertension, Con						1	Yes 2™No		bably 4 Unknown
Vital Records,	law re las be 2 sh	ple	Congestive Heart	Failure	, Aort	icster	osis,		24a. Was		b. Were aut prior to c death?	opsy findings available ompletion of cause of
<u>~</u>	: The cate h	S	Fraility, Cauhexi	La					1 Yes	2 🔯 No		2 □ No
Vita	Physician: The lavithis certificate has	Be	25. Was case referred to medical examiner?	Hospital:	nationt 25	☐ ER/Outpatie	ent 3 DOA Ot	26. Place of Dea	ith <i>Check on</i> Iome 5 ☐ Res		ther (Spec	ufy)
o		n: To	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of		28b. Time Injury	of 28c. Inju			how injury occ		,,
ion	Attending Fir death. sector: After by the funer	atio	1 ⊠Natural 5 □ Pending 2 □ Accident investigation		, Day 10ar,	Шусту		Yes 2□No				
Division	or Attender de Directo	Certification:	3 Suicide 6 Could not b 4 Homicide determined	200. F 1800 C	of Injury - At g, etc. <i>(Spec</i>		street, factory, office			(Street and Nui own, State)	mberorRu	ral Route Number,
]	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exer	ysician: To the base	sis of examin	nowledge, dea	ath occurred at the t investigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time	a cause(s) and , date and plac	manner as e, and due	stated. to the cause(s)
	o the ithin 2 o the amplel	Med	29b. Signature and title of certifier	C 2			29c. Licen	se number		29d. Date sig	ned (Month	n. Day, Year)
	F ¥ F 8		R. Suyan	Sunda	W		D53	367		Jul	y 25,	2006
	2041		30 Name and address of person who	completed cause	of death (Ite	em 23a) (Type	e. Print)		05 07	3.5	4 .	00000
	σ		Rajan Shymamsund	ar M.D.	3411 ()landwo	ood Court	, Suite l	.05, 01n	ey, Mar	91.and	L 4U834
	St Regis	ate	31. Date filed (Month, Day, Year) AUG 0 1 2	006	gistrar's Sig	natuly.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tell 4a per doc 8558 8-1-06 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 0 200, Grace Evelyn Yates 4g-County of Death 4a. Facility Name (If nFRANKLIN STOUARE HOSPITAL 4b. City, Town, or Location of Death 05 0 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Linder 1 Year 5. Social Security Numbe Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 1 ☐ M 2 🕃 F 7,1934 213-38-9311 Virginia Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Harford **Edgewood** 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 2307 Rosewood Drive 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 22 Married 1 ☐ Yes 2 No 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Shoe Manufacturer Machine Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Kelly Hagy Margerie Lynn Lucille Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann M. Yates/ Daughter-in-law 110 Fairmont Drive, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 7-27-06 Towson, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) colon concer 3 months Metastatic Due to (or as a consequence of): Due to for an a consequence off Due to (or as a consequence of) 23b. Was decedent pregnant

Physician /Medical Examiner

nding physicien and use as the burial-transit certificate be executed

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Certification:

Medical

permit. Pages 1 end 2 is Department of Health ar Important: If item 27 is eny injury or other trau

altimore.

Box 68760

P.O.

Records,

Division of Vital Hospital or Attending Physician:

The law requires that the death

Physician

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Examiner

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Completed

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7 is marked other then "naturel", or items 23a or 28e-f ebor traumatic event, the Modical Examiner must be notified at

1 end 2 should be filed within 72 hours after death with Health and Mental Hygiene. em 27 is marked other then "naturel", or items 23s or

the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 4□Pregnant at time of death

9□ Unknown

Hospital: 1 Inpatient

28a. Date of Injury (Month, Day Year)

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 ☐ Yes 2 PNo 27. Manner of Death 1 Natural 2 Accident

examiner?

3 Suicide

4 | Homicide

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical

5 Pending investigation 6 Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 DOA

28c. Injury at Work?

2 ER/Outpatient

28b. Time of

Injury

28f. Location (Street and Number or Rural Route Number. City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

KNONNE

29c. License number

29d. Date signed (Month, Day, Year)

-Olta-MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D40850

July 270, 2006

State Registrar 31. Date filed (Month, Day, Year) AUG 0 1 2006

9103 Franklin Synch Dr. Breto. MB 21237 OTTAVIANO

MA

		-	For State Registrar		State of	Marylan		artmen rtificat			ind M	lental Hy	giene Reg. No.	006	24082
	Physicia	an	Decedent's Name (First, Mide Anna Veror			mor			-			2. Date of De Month	Day	Year	3. Time of Death 8:47 p ^M
9	/Medic	al	4a. Facility Name (If not instituti					4b. City,	Town, or	Location of	f Death	July	28 4c. C	2006 ounty of Deat	
	Examin	er	703 Snowk	-					sex				Ва	ltimo	re
	Funeral Director		5. Social Security Number 213-16-4451	6. Se	-	Age (In yrs. I	* .	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir Month, Da	th 2/192	9. Birth Co Mar	hplece (State or Foreign unity) Cyland
	and		Usual Residence of Decedent 10a. State 10b. Coun	ty		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Mary Find	to	Maryland Balt	imor	æ		Essex								1 ∐ Yes 2 ∐XNo
	th with the 23s or 28s ist be not	Funeral Director	10e. Street and Number 703 "C" Snowb	erry	Court			10f. Zip	2122		-		U.	on of What Co	untry?
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heatilt and Mental Hyglene. Department of Heatilt and Mental Hyglene. Important: If Itam 27 is marked other then "natural", or Itams 23s or 28s-f show stripping or other traumatic avant. It is Modical Examinar must be notified at once.	by Funer	11. Marital Status 1 □ Never Married 2 □ Ma 3 ▼ Widowed 4 □ Divorce	1	12. Was Deced Armed Forc 1 Tes 2 If Yes, Give Year or Date	es? X No		Was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specify:	gin? (Sp , Puerto	ecify Yes or No Rican, etc.)		. Race - Ame Black, White pecify: W	
Maryland 21215-0036	ithin 72 hou ne. nen "natura e Medical E	Completed	15. Deceding (Specify only high Elementary/Secondary (0-12	est grad		lor 5+)		kind of wo DO NOT u	rk done d se retired	ntion fu <i>ring m</i> os)	t of work	ing		of Business/	
121	lied w Hygier har th		12 17. Father's Name (First, Middle	e (ast)			Ca	shier	: 	18. Mothe	r's Name	(First, Middle			re
ylanc	should be find Mental Harmarked of	To Be	Frank Mack		0.00		405 14-16		///	Ca	the	cine Pi	etrok		Tip Code)
	alth and 27 is m		19a. Informant's Name/Relation Sandra M. Fisc			er)	703'	C" Sr	owbe	erry (Cour	Essex	, Mar	yland	21221
ore	ges 1 a it of He if itam or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation			ate	lace of Dispo emetery, cre			ə)	7/ 20	Date 31		ation - City or	
Baltimore,	permit. Pa Departmer Important any injury once.		4 Donation 5 Other 21. Signature of Funeral Service			Bay	view C			s,of Eacilit		06 1 Home		imore,	Maryland
8	89 <u>F</u> 8		1/0- 15	9	22	/ 0	1	407 (old F	aster	n A	venue F	ssex.	Maryla	nd 21221
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3,092	Examiner	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	$\left\{ \right.$	bDue to (o	r as a conseq r as a conseq r as a conseq	uence of):								
P.O. Box 68	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Physician/Med	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			th 2 ☐ Feta nt at time of d	Ideath 3	⊒Ectopic p ⊒ Other (sµ					23	d. Date of del	ivery Day Year
	8 6 6	þ	Part II. Other significant cond	itions c	ontributing to dea	th but not res	ulting in the u	inderlying o	cause give	en in Part I			tobacco us Yes 2 🗆		the cause of death?
Records,	e iaw hes b	Completed												24b. Were au prior to death?	utopsy findings available completion of cause of
Vital	ysician: Th is certiticete director, pag	Bec	25. Was case referred to medi examiner?	cal					101		of Deat	h (Check only	one)		
on of \	ling Phys I. Atter this luneral dii	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pen 2 Accident	ding stigation	28a. Date of (Month	patient 2 Injury , Day Year)	28b. Time of Injury		28c. Injun Worl	4 🗆 NI		me 5 Res 28d. Describe			cify)
Division of	To the Hospital or Attending Is within 24 hours atter death. To the Funeral Director: Atter completely filled in by the tuner	Medical Certification:	3 ☐ Suicide 6 ☐ Cou	_	28e. Place of	of Injury - At hig, etc. (Specif	ome, farm, st	reet, factor	y, office				(Street and wn, State)	Number or Ru	ural Route Number,
	Hospit: 24 hours Funers	dical (ysician: To the to	sis of examina									
	To the within !	Mec	29b. Signature and title of cert	fier	and mailin			29	c. Licens	e number			29d. Date	signed (Mont	h, Day, Year)
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	1	-	30. Name and address of pers	on who	completed cause	of deat (Iter	n 23a) (Type	Print)	Ha.	il.	n n	210	100		
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	Regist		ALIC	0 1	2008	CAUMI	10.	1							

		4	State	partment of Health and M ertificate of Death		711116 751183
			Registrar 1. Decedent's Name (First, Middle, Last)	erinicale of Death	Reg. N 2. Date of Death	3. Time of Death
	Physicia	an	I. Michael Zakrjewski, III		7/31/2	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 1244 East Fort Avenue	4b. City, Town, or Location of Death Baltimore		c. County of Death N/A
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 217-66-7884 2 F 53 Yrs.	Months Davs Hours Min.	8. Date of Birth (Month, Day, Year 5/10/19	9. Birthplace (State or Foreign Country) MD
	pu »		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or	Location		10d. Inside City Limits
	Maryla f ehor	5	MD N/A	Baltimore City		1 Thes 2 □ No
	with the I a or 28e-	Director	10e. Street and Number 1244 East Fort Avenue	10f. Zip Code 21230	-	itizen of What Country?
0	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other then "natural", or Itams 23a or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at ance.	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto □ Yes 2♥ No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
	2 hours e atural', o	ted by	3 Widowed 4 Divorced Fear or Dates: 15. Decedent's Education 16a. De	1 ☐ Yes 2 ☑ No Specify: cedent's Usual Occupation ive kind of work done during most of works	16b.	Kind of Business/Industry
2	thin 73	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) Contractor		nstruction
7	Hygien Hygien Ther th		17. Father's Name (First, Middle, Last)		(First, Middle, Maide	
	id be f ental h ked of ic eve	To Be	Ignatius M. Zakrjewski	Mary Co	egelski	
Mary	id 2 shouth and M		19a. Informant's Name/Relationship (Type, Print) Mary Bolton / Mother 19b. M	ailing Address (Street and Number or Rura 244 E. Fort Avent	Namber City 1e, Balti	nor Town, State, Zip Code) More MD 21230
more,	Pages 1 an ent of Heal nt: If item 2 ry or other		ZOA. WIGHTON OF DISPOSITION	sposition (Name of Crematory or other place) Hill Cemetery 08		Location · City or Town, State Baltimore MD
Dalti	permit. I Departm Importa any inju		Signature of Funeral Service Licensee Victor P. Doda, J.	22. Name and Address of Eacility Charles L. Ste 1501 E. Fort	evens Fur Avenue, I	neral Home, Inc. Baltimore MD21230
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о.	res that the de signed by the signed be	, Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
rds	w requires been sign should be	ed by			1 🗌 Yes	20 No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records,	Physician: The law requires that the this certificate has been signed by the director, page 2 should be detached.	Completed			24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?
ita		BeC	25. Was case referred to medical examiner?		h (Check only one)	
5	hysic this ce al dire	2	1 Yes 2 No 1 Inpatient 2 ER/Outp		me Hesidence 28d. Describe how in	6 ☐ Other (Specify)
o o	Jing I After funer	tion:	1 Natural 5 Pending (Month, Day Year) Inju		200. Describe now in	jury december
Divisi	or Attendi efter death Director: A	Certification:	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm building, etc. (Specify)	s, street, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
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)	To the To the comple	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23a) (To 30c) 3cm beauty 50c Street 13cm	pe. Print) DAVID		- NO, NO
	St Regist	tate trar	30. Name and address of person who completed cause of death (Item 23a) (Tr. 3 oc.) South Equation 5 to 2 oc. 1 Sou	barle		

		For State Registrar	State o	f Marylan		rtment tificate			ınd Mer		iene eg. No.20	06	24084
Physic		1. Decedent's Name (First, Middle, Rita Glaese	,	k i						Date of Deat Month July 26	Day	Year	3. Time of Death 1:10 P M
/Med Exami		4a. Facility Name (If not institution,				4b. City, 1	Town, or	Location o		, any man	4c. County		1.101
		Stella Maris	Hospice				oni				Balt	imore	3
Funeral Director		5. Social Security Number 220-14-6076 Usual Residence of Decedent	3. Sex 1 ☐ M 2/CX F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, 26. 26)	Year)	Cour	lace (State or Foreign htry) Land
d within 72 hours after death with the Maryland yiene rithen "neture!, or Iteme 23e or 28e-f ehow the Madical Examiner must be notified at	by Funeral Director	10a. State 10b. County Maryland Baltim 10e. Street and Number 4 Cameron Dri 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	VC 12. Was Dec	Badent Ever in U. rices? 2 致No	1	10f. Zip	236 ent of Hi rfy Cuba	spanic Orig n, Mexican Specify:	gin? (Specify , Puerto Ric	y Yes or No- an, etc.)		What Cour ce - Americ ck, White,	an Indian,
72 hours af	Completed t	15. Decedent's (Specify only highest	Education	a103.	16a. Deced	dent's Usua kind of wor	l Decupa k done d	ition luring most	of working		16b. Kind of B		
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2 should be and Mental is marked eumatic ev	ို	19a. Informant's Name/Relationshi			19b. Mailir	ng Address	(Street a				r, City or Town,	State, Zip	Code)
1 and 1 and Health em 27		Dennis J. Zubr 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 4 □ Donation 5 □ Other (Sp	3 □Removal from	State	103 Place of Disponentery, cremitalltop	sition (Nam natory or of	ne of The	θ)	Date		MD 21 20c. Location	- City or To	
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* £ 5 8	5	Part II. Other significant condition	ns contributing to d	eath but not res	sulting in the u	nderlying c	ause give	en in Part I.					ne cause of death?
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VISION Attention of the officers by the	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place	e of Injury - At h ling, etc. (Special	ome, farm, st fy)					Location (S City or Tow		ber or Rur	al Route Number,
Hospita 4 hours Funerel	edical C	29a. Certifier 1X Certifying (Check only one)	Physician: To the seaminer: On the band man	e best of my kno casis of examina ner stated.	owledge, deal ation and/or in	h occurred vestigation	at the tin , in my o	ne, date an pinion, dea	nd place, and th occurred	d due to the o at the time, o	ause(s) and m date and place,	anner as s and due t	tated. o the cause(s)
To the within 2 To the complet	Ne Ne	29b. Signature and title of certifier)			290	. Licens	e number		2	29d. Date signe		
,- ,- 0			/				DY	372	.J		7/	126/	106
4		30. Name and address of person of DR. TARIO MAHM		se of death (Ite). '	LTWUM.	тим. м	D 2109			
	tate	31. Date filed (Month, Day, Year)		Registrar's Sign		-14.1			1 L	- 41V			
Regis	trar	AUG 0 1 2	006	un li	Bos								

DHMH 17 Rev 1/2001

JULY 26, 2006

RITA ZUBROWSKI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2066 - 24085 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2" 70PM **Physician** Florence V. Zentgraf 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical mi Burnie timore Mushingen 5 201 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Davs Hours 1□M 2□F 215-12-4564 84 Director Maryland Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show r than "natural", or itema 23a or 28a-f showing the Medical Exemples of the mutilities of MD Baltimore 1 Yes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3102 Westfield Avenue 21214 U.S.A. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11th grade Operator Can Company permit. Pages 1 end 2 should be filed v Depertment of Heelin and Mental Hygies Important: If item 27 is marked other ti any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward E. Zentgraf Anne Stedding 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Whitt, sister 107 Allen Road, Glen Burnie, MD 21061 Baltimore. Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cem. July 31, 2006 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 21. Signature of Funeral Service Licenses 6415 Belair Road, Baltimore, Maryland 21206 w 23a. Part1. Enter the disease, Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, It any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner ending physicien and use as the burial-transit Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown ete hes been signed l page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HIS 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No certificate 1 ☐ Yes 25 No After this certifice funeral director, J or Attending Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To Division of 28b. Time of 27. Magner of Death 28d. Describe how injury occurred Injury Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital within 24 hours To the Funeral 15 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical completely (Check only one) eu. 29d. Date signed (Month, Day, Year) nd title of ertifie 29b. Signature 30. Name and address of person who/completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006

Registrar

0 1

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Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		Registrar	ate of Death	Reg	No. 2006	2408
Physicia	n/	1 Decedent's Name (First, Middle,Last)		Date of Death Month D	ay Year	3. Time of Death
ledical Examin		Julia Dianna Banos		July 17, 200		1106 hrs
		4a. Facility Name (if not institution, give street and number) 114 West Franklin Street # 2M	4b. City, Town, or Location of De Hagerstown	eatn	4c. County of Death Washington	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birt)	l	Hrs. 8 Date of Birth(MM/DD/YYYY) 9. Birth	place (State or
Director		222-36-7253 _{1 M 2 X F} 55	Months Days Hours Yrs.	Min. 06/07/1	951 Foreign Cour	itry) NC
	E	Usual Residence of Decedent				
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hours after death with the Maryland matural", or items 23a or 28a-f sho Examiner must be notified at once	Director	114 West Franklin Street #2M	10f. Zip Code 21740	10g.	Citizen of What Countr US	y r
ith the	L	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - America	an Indian, Black,
eath w	Funer	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Pu		White, etc.	
after d		3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify		Specify: W	nite
hours			Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		Sb. Kind of Business/Inc	dustry
C1 3 -	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	None		None	<u> </u>
5-0036 lled within 72 Hygiene. I other than the Medical	팅	17. Father's Name (First, Middle, Last)	_	ame (First, Middle, Mai		
	Be	Calvin John Hogan		belle (unk		
			b. Mailing Address (Street and Number			
	-		220 N. Potomac Stre		Oc. Location - City or To	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematic	tory or other place)			
o in	-	4 Donation 5 Other Specify: Smith 21 Signature of Euneral Service Licensee	nsburg Crematory 0	//21/2006	Smithsburg	g, MD
Balt permit. Depart Import		21 Signature of Ethieral Service Licensee	22. Name and Address of Facility G	Gerald N. M	innich Fund	eral Home
Physician	+	23a. Part I. Enter the disease, or complications that caused the death. Do no	ot enter the mode of dying, such as cardi	ac or respiratory arrest	shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	-	failure. List only one cause on each line. Immediate Cause (Final disease a Atherosclerotic can	rdiovascular disease			Death
-xammer		or condition resulting in death) Due to (or as a consequence of).				
- I want	<u>ا</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			3	
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ords, aw requir as been a	plet			autopsy	prior to co	mpletion of cause of
tal Rec	Completed			1 ✓ Yes 2	No 1 ✓ Yes	2 No
ital ician: s certif	Be .	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/C	26 Place of Death (Ch Outpatient 3 DOA Other, No.		sidence 6 🗸 Other:	Scene
1 of V ding Phys After thi funeral di	P	1 Ves 2 No Impation 28a. Date of Injury 28b.	Time of Injury 28c. Injury at Work?	28d Describe how		
ion c tending eath. tor: Af the fun	ij	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stafer death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, to	farm, street, factory, office building, etc	28f Location (Stre	eet and Number or Rura	al Route Number, City
Dispital cours a filled	Certification:	4 Homicide determined (Specify)		(1)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a Certifier 1 Certifying Physician: To the best of my knowledge, de (check only one) 2 Medical Examiner: On the basis of examination and/or				
To the within 2 To the complet	Medical	and manner stated 29b. Signature, and title of certifier	29c. License number		9d. Date signed (Mont	
		In the stand of	O.C.M.E.	<u> </u>	July 18, 2006	
		30. Name and address of person who completed cause of death (Item 23a)				
SH0		Pamela Sputhall, MD Assistant Medical Examiner	111 Penn Street, Baltimore, I	MD 21201		
St	ate	31. Date filed (Month, Day, Year) 32. Relistrar's Signature	Marks.			
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			Registrar 1. Decedent's Name (First, Middle, Las	1)			2. Date of Dea	ath	3. Time of Death
	Physicia /Medic		Amelia Agnes BOGI	JSZEWSKI			July 16	5, 2006 Year	11:35 p.M
Ì	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Location		4c. County of Deat	
			11521 Del1wyn Dra 5. Social Security Number 6. Se		(In yrs. last birthday)	Hagerst	OWN or 24 Hrs. 8, Date of Birtl		ngton
	Funeral Director			M 2⊠F	82 Yrs.	Months Days Hours	Min. (Month, Day	γ Yθar) 5, 1924 Pe	hplace (State or Foreign nuntry) nnsylvania
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	with t	Ö	10e. Street and Number 11521 Dellwyn Di	cive		10f. Zip Code		USA	ondy:
	ns 23	ıera	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13.	Mas Decedent of Hispanic O f Yes, specify Cuban, Mexica	origin? (Specify Yes or No-		
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23s or 28s-f show or other traumatic avent, the Medical Exam an inful is molified at	by Funerai Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 No If Yes, Give		1 Tes, specify Cuban, Mexica 1 ☐ Yes 2 💢 No Specify		0	hite
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Baltimore,	permit. Pages 1 a Department of Hes Important: If itam any injury or otha		21. Signature of Funeral Service Licen		22	Name and Address of Faci		FUNERAL HOM	
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n 2 .			30. Name and address of person who	completed cause of de	ath (Item 23a) (Type,	Print) Media	21/16	W RIDI	
	7-6	10	31. Date filed (Month, Pay, Year)	32./Ragistra	r's Signature	1101-606	WXT IST	Not H	D 4742
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ORIGINAL

			For State Registrar	State of	Maryland / Depa <i>Cei</i>	artment of Hertificate of E			giene []	96	24088
			Decedent's Name (First, Middle,	Last)				2. Date of Dea		Vaar	3. Time of Death
	Physicia		Bruce A	llan	Bauer			Month July 1	Day 6. 2006	Year	2:15 p M
	/Medic Examin		4a. Facility Name (If not institution,	give street and numb	er)	4b. City, Town, or	Location of Death	DULY	4c. County		2.1.2
		eı	Anne Arundel Me			Annai	polis		Anne	e Aru	ındel
-	Funeral				Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1		place (State or Foreign
	Director		229-34-2952	1 X) M 2□ F	75 Yrs.	Months Days	Hours Min.	(Month, Da) Apr. 1			ington,DC
			Usual Residence of Decedent								
	ylan		10a. State 10b. County		10c. City, Town or Lo	ocation				1	10d. Inside City Limits
	Mar Feet	to	MD Anne A	rundel	D	eale					1 ☐ Yes 2 X No
	r 28c	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Cour	ntry?
	3e o		6041 Melbourne	. Avenue		20	751		U.S.	.A.	
	within 72 hours after death with the Maryland ene. then "returel", or items 23e or 28e-f ehow he Medical Examena inuation notified at	Funeral Director	11. Marital Status	12. Was Decede		Was Decedent of His	spanic Origin? (Spe	cify Yes or No-		ce - Americ	
10	in the state of th	Ē	1 ☐ Never Married 2X Marrie	Armed Force ad 117 Yes 2 If Yes, Give		If Yes, specify Cubar		rican, etc.)		ick, White,	OIC.
ဗ္ဗ	ol', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	s:1954-79	1 ☐ Yes 2XX No	Specify:		Specif	^{y.} whi	ite
21215-0036	72 hours "neturel", idical Exe	Completed	15. Decedent'	s Education	16a. Dece	dent's Usual Occupa	tion	ina	16b. Kind of B	usiness/In	dustry
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77	the.	E	Elementary/Secondary (0-12)	5+		vy Comman	der		U.S. Na	avy	
	filed Hygid other ent.		17. Father's Name (First, Middle, L				18. Mother's Name	e (First, Middle.	Maiden Suman	ne)	
an	d be ental ked c	To Be	David F.	Bauer			Margar	ret	Wil	lliam	ıs
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Ma	d 2 s th ar t7 ls treu		Nancy Bauer, wi	1211	6041	Melbourne	Ave., De	eale, MI	2075	1	
	permit. Pages 1 and 2 Department of Health mportent: If item 27 any injury or other tru		20a. Method of Disposition		20b. Place of Dispo	osition (Name of		Date	20c. Location	- City or To	own, State
ō	it of it of or o		1 ☐ Burial 2 🂢 Cremation		ate cemetery, cre	matory or other place			77	7	7.73
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Baltimore,	permit. Pages Department of I Importent: If ite any injury or of		21. Signature of Funeral Service L	icensee	0	2. Name and Addres	Nat	ısch Fur			
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			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that date only one cause on each	ITI IMO.	1			rest.		Approximate Interval Between Onset and Death
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۵.	requires that the death certifi seen signed by the attending I hould be detached for use as	P.	Part II. Other significant condition	ns contributing to dea	th but not resulting in the u	ınderlying cause give	en in Part I.	23e. Did to	obacco use con	tribute to t	the cause of death?
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Records,	w requires that been signed to should be deti	Completed									
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Ĕ	The law rate has b page 2 sl	E						perfo 1 ☐ Yes	rmed?	death?	2 No
Vital		a)	25. Was case referred to medical				26. Place of Deat	h (Check only o	ne)		
>	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	patient 2 ER/Outpatie	nt 3 DOA Othe	er: 4 ☐ Nursing Ho	me 5 ☐ Resid	dence 6 🗆 Oth	her (Speci	fy)
of			27. Mann eath	28a. Date of	Injury 28b. Time of	-		28d. Describe h			,
on	Attending I ir death. ector: After by the funer	tlor	1 Natural 5 Pending 2 Accident investig		Day Year) Injury		r? Yes 2 □ No				
2	death. ctor: A y the fu	ica	3 ☐ Suicide 6 ☐ Could r	ot be	of Injury : At home, farm, st	reet, factory, office		28f. Location (5	Street and Numi	ber or Rur	al Route Number,
Division	or A after Direction by	Certification:	4 Homicide determi	building	g, etc. (Specify)	,,,		City or Tov	vn, State)		
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	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	one)	and manne		29c. License	number		29d. Date signe	ed (Month	Day Year)
	To To	2	29b. Signature and title of certifier	//		250. License	1		23d. Date Signe	, I	Jay, rear
			Cul	iltan	mn		15330	6	7/1	6/0	6
			30. Name and address of person	who completed cause	of death (Item 23a) (Type	, Print)			t		
- 1	5+1		Curtis Harr	is und	900 Bests.	ete Rel	Annapa	115 14	10 21	40	
		ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature						
	Regist		JUL 1 9 200	1 per sur	of death (Item 23a) (Type						

If Under 1 Year

10f. Zip Code

3. Time of Death

4:35 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

Mexico

Day

16

8. Date of Birth (Month, Day, Year) April 26 1921

JULY

18. Mother's Name (First, Middle, Maiden Surname)

7/17/06

Box 5038, Laytonsville, Md. 20882

Durand

Guadalupe

19221 Mt. Airey Road, Brookeville, Md.

22. Name and Address of Facility
Muriel H. Barber Funeral Home

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4b. City, Town, or Locetion of Deeth

Sandy Spring

If Under 24 Hrs.

20833

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 No Specify: Mexican

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Executive Officer

Year

Montgomery

Race - American Indian, Black, White, etc.

Public Information

White

2006

4c. County of Deeth

10g. Citizen of What Country?

Mexico

Specify:

16b. Kind of Business/Industry

20c. Location - City or Town, State

Alexandria, Va.

Physician

/Medical

shock, or heart failure. List only	one cause on each line.	III. DO NOI BINEI IIIB III	oue or dying, such as cardio	ac at toophototy officety	Interval Between Onset and Death
Immediate Cause (Final disease or condition	a Con	gestive	heut for	ilure	days
resulting in death)	Due to (or as a consequence of	of):		1
Sequentially list conditions, if any, leading to immediate	bDue to (or as a consequence o	π _j .		
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (c	or as a consequence of	f):		
Part II. Other significant conditions o	dontributing to death but not re-	sulting in the underlying	g cause given in Part I.	23b. Did tobacco use of	contribute to the ceuse of death?
				1 □ Yes 2 No	3 □ Probably 4 □ Unknown
				24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
				1□ Yes 2 No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical			26. Place of Do	eath (Check only one)	
examiner?	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐	DOA Other: A Nursing	Home 5 ☐ Residence 6 ☐ C	ther (Specify)
27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work?	28d. Describe how injury occ	urred
3 ☐ Suicide 6 ☐ Could not b	288. Place of Illigary - Act	nome, farm, street, fact	tory, office	28f. Location (Street and Num City or Town, State)	mber or Rural Route Number,
29a. Certifier (Check only one) 12 Certifying Ph	nysician: To the best of my knowniner: On the basis of examinated and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date end plaction, in my opinion, death occ	ce, and due to the cause(s) and curred et the time, date and plac	manner as stated. e, and due to the cause(s)
29b. Signature and title of certifier	Divier				ned (Month, Day, Year)
· ally that	- FAYSICIES		D0055694	July	16,2006
Λ				MD 20022	
ALOK MATI	HUR 40	200 R+ 1	08 Olsey,	MD 20832	
31. Date filed (Month, Day, Year)	32. Registrar's Sign	H Spark	E Common and the comm		
	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions of the conditions of th	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (d	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of death but not resulting in the underlying in t	Immediate Cause (Final disease or condition resulting in death) Beginning in death) a.	Immediate Cause (Final disease or condition resulting in death) Bue to (or as a consequence of): Due to (o

Certificate of Death 2. Date of Death

7. Age (In yrs. last birthday)

10c. City, Town or Location

Brookeville

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

P. O.

85

Apt. #9

12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

College (1-4or 5+)

BARKER

Brooke Grove Rehabilitation-Nursing Center

1 M 212 F

Montgomery

1. Decedent's Name (First, Middle, Last)

LUISA

4a Facility Neme (If not institution, give street and number)

10h County

19109 Georgia Avenue,

15. Decedent's Education (Specify only highest grade completed)

Huarte

Nancy R. Nullmeyer / Niece

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

MARIA

5. Social Security Number

10e. Street end Number

10a. State

Director

Funeral

þ

Completed

Be

Md.

215-52-8591

1 Never Married 2 Married

3 ☑ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

12

Mariano

20a. Method of Disposition

Usual Residence of Decedent

		1 - For State Registrar	State of Maryla		artment			nd Me		iene g. No. 200	16	2409
Physici /Medio Examir	al	Decedent's Name (First, Middle, Last, Herbert E. E Aa. Facility Name (If not institution, give	ates		4b. City,	Town, or	Location of		2. Date of Death Month July			3. Time of Death 6:10A
Funeral	(C)	Spring House Manor 5. Social Security Number 6. Sec	Care	s. last birthday) 6 Yrs.	If Under Months	ethe 1 Year Days	sda If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Jan. 04	Montgo	9. Birthp Coun	y lace (State or Forei try) W York
ס	ctor	Usual Residence of Decedent 10a. State	10c. C	City, Town or Lo					Jan. 04	, 1)20		0d. Inside City Limi
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: if Item 27 is marked other then "naturel", or Iteme 23e or 28e-f ehow ethy injuryor other traumatic event, I'm Medical Exa villar fuals fe notified at once.	Completed by Funeral Director	10e. Street and Number 5524 Parkston Roa 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad	12. Was Decedent Ever in Armed Forces? 1 [X]Yes 2 □ No If Yes, Give Year or Dates: WW] cation e completed)	I I 16a. Dece	Was Deced If Yes, spec 1 Yes 2 dent's Usua kind of wor	208 ent of His fly Cubar 2 X No	spanic Origin, Mexican, Specify: tion uring most	Puerto R	cify Yes or No- lican, etc.)	U. S 14. Race- Black, Specify:	Americ White,	an Indian, etc. iite
hould be filed with id Mental Hygiene. marked other ther matic event, III.	To Be Com	17. Father's Name (First, Middle, Last) Herbert 19a. Informant's Name/Relationship (Ty	College (1-4or 5+) 5+ ates	Admin:			18. Mother	's Name	(First, Middle, M Lanagan	U.S. Go		
Pages 1 and 2 sinent of Health and the site of Health and the street of		Patricia Bardenwer 20a. Method of Disposition 1 X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	per/Daughter 20b. Removal from State		Searl sition (Nam	Ter	race	, Be	thesda.		816 ity or To	wn, State
permit. Depertr Importe eny inju		21. Signature Filmeral Service licens	S. C.	22	222 Wi	iscor	nsin A	Ave.,	N.W. W	ral Hom Washingt	е	D.C. 200
Physician /Medical Examiner publication and physician and physician and physician and physician are perfectly as a second physician and physician are perfectly as a second physician and physician are perfectly as a second physician are perfectly	Ilcal Examiner	23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequential / Bist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Ischemic Due to (or as a conse Type I D: Due to (or as a conse Due to (or as a conse Due to (or as a conse	Cardion equence of):	myopa	thy						Approximate Interval Between Onset and Death years years
Attending Physician: The law requires that the death certificate be executed rideath. rideath. setor: Atter this certificete hes been signed by the attending physician and y the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pro					23d. Date of Month		ry Day Year
law requires that es been signed b 2 should be deta	Completed by Ph	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying ca	ause give	n in Part I.		1 ☐ Ye	s 2 🔀 No 3	Prob	e cause of death? ably 4 □Unkno
ysician: The lav is certificete hes director, page 2	e Com	25. Was case referred to medical					26 Place	of Death	autopsy perform	ned? dea ☑No 1 □	ath?	npletion of cause of
Attending Physicis or death. octor: After this cer by the funeral direct	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		8c. Injury Work	4 Nur	sing Hom	e 5 Reside	nce 6 QOther w injury occurred	(Specify	Assisted Living
in the	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	oify) 					City or Town			
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Phy 2 ☐ Medical Exami	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	vestigation,	in my op	inion, death	place, ar	d at the time, da	use(s) and mann te and place, and	d due to	the cause(s)
Z in S		30, Name and address of person who co		00:15		D258				July 12		
Sta Regist		Sean M. Dwyer, M 31. Date filed (Month, Day, Year) JUL 17 20	.D. 5454 Wis	consin	Ave.	#92 <u>5</u>	Beth	nesda	, Md. 2	0815		

		1	For State Registrar	State of Maryland			t of Healt e <i>of Dea</i>			giene Reg. No	006	24091
	Physicia	an	1. Decedent's Name (First, Middle, Last) Laila			Begu	m		2. Date of Dea Month July	14 ^{Day}	2006ar	3. Time of Death 12:25А. м
>	/Medic Examin		4a. Facility Name (If not institution, give str 15428 Indianola				Town, or Locat kville	ion of Death			ounty of Death ontgomen	ry
	Funeral Director		5. Social Security Number 6. Sex 1 D N	7. Age (In yrs. la 92	st birthday) Yrs.	If Under Months	1 Year If Ur Days Hou	nder 24 Hrs. urs Min.	8. Date of Birtl	913	9. Birthp	lace (State or Foreign
	D		Usual Residence of Decedent 10a. State 10b. County Maryland Montgomery		Town or Lo Rockv		Code			10g Citize	on of What Cour	0d. Inside City Limits 1 ☐ Yes 2 🌠 No
	23a or 2	Funeral Director	10e. Street and Number 15428 Indianola Dr			20	0855			Uı	nited St	tates
5-0036	ours after des	by Funer	11. Marital Status 12 1 □ Never Married 2 □ Married 3 ☐ Widowed 4 □ Divorced	. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2√ No If Yes, Give Year or Dates:	'	Was Dece f Yes, spe 1 Yes	city Cuban, Me	c Origin? (Sp xican, Puerto cify:	ecify Yes or No- Rican, etc.)		Black, White,	
21215-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Itame 23a or 28a-f show any injuryor other traumatic event, Ita Medical Examinat must be notified at once.	Be Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		16a. Deced (Give life. I	kind of wo DO NOT u	al Occupation rk done during se retired)	most of work	ing		wn home	
Maryland 2121	lid be filed lental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last) Kurban Husain					Mother's Nam atima	e (First, Middle, Begum	Maiden S	umame)	
Mary	nd 2 shou lith and M 27 ie mar r traumat		19a. Informant's Name/Relationship (Types Shamoon Husain -son						a <i>l Route Numbe</i> : Bristo			20136
Baltimore,	Pages 1 a lent of Hea nt: If Item		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Rei 4 □ Donation 5 □ Other (Specify)	moval from State Mary	ace of Dispo metery, crer yland	sition (Na matory or o Nati	me of other place) onal Me	1	Date 7/14/2		ation - City or To Laurel, M	own, State Maryland
Balti	permit. DepartmImporta any Inju		21. Signature of Funeral Service Licensee	ngward	4.	400 F	owder N	<u>/ill Re</u>		svil.	ne, PA le, Mar	yland 20705
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death, cause on each line. CEREBRO Due to (or as a consequ	VA	er the mod	0	ch as cardiac	-	rest,		Approximate Interval Between Onset and Death 7-6-06
8760,	ate be executed mysicien and he burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence to	Sc/ E	RoTI D	C HEASE	RT I)ISEASE			
Box 6	death certific e attending p id for use as	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	⊒Ectopic p ⊒ Other (s				23	d. Date of delive	ery Day Year
ds, P.O.	es tha gned be de	ρ	Part II. Other significant conditions control	ributing to death but not resu	Iting in the u	ınderlying	cause given in I	Part I.	23e. Did to	7.7		he cause of death?
Vital Records,	The law ate has t page 2 s	Completed							24a. Was autor perfo 1 🗆 Yes		24b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
f Vita	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	ospital: 1 Inpatient 2 I	ER/Outpatie	nt 3 D			th <i>(Check only c</i> ome 5∑ Resi		Other (Speci	(y)
ion of	ding h. After fune		27. Macher of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of M	28c. Injury at Work? 1 ☐ Yes		28d. Describe			
Division	in Pite	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	reet, facto	y, office		28f. Location (City or To		Number or Run	al Route Number,
	Hospital 24 hours a Funerel ietely filled	Medical (29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examination	cian: To the best of my know er: On the basis of examinat and manner stated.	wledge, deal ion and/or in	th occurred	d at the time, da n, in my opinion	ate and place n, death occu	, and due to the rred at the time,	cause(s) a date and p	and manner as s place, and due t	stated. to the cause(s)
	To the l	Ň	29b. Signature and title of certifier	outp.			013668	nber			1y 14 ,	
			30. Name and address of person who cor Azher Hussain, M.D.				llege Pa	ark, M	aryland	2074	0	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32 Registrar's Signal								

State of Maryland / Department of Health and Mental Hygiene 26092 For State Registrar Certificate of Death Rag. No. 3. Time of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 1²4, JUIV **Physician** Edith E. Beckford 2006 7:45P. M /Medical 4a. Fecility Name (If not institution, give street and number)
Holy Cross Hospital 4b. City, Town, or Location of Death Silver Spring 4c. County of Death Examiner Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Sept. 30, 1931 9. Birthplace (State or Foreign 5. Social Security Number 7 Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 T F 74 592-70-9596 Jamaica Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "neturel", or iteme 23s or 28s-1 show very intury of other treumatic event, if a Medical Exeminer must be notified at once. 1 ₹ Yes 2 No Director Florida Dade North Miami Beach 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1540 N.E. 191 Street, #245 33179 United States Peges 1 and 2 should be filed within 72 hours after death 1 nent of Heelth and Mental Hygiene. ant: If item 27 ie marked other then "neture!", or iteme 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **Black** Specify: 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) Simpson 17. Father's Name (First, Middle, Last) Wilfred Be Hanson ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3603 Collier Road Beltsville, Maryland 20705 Maurice A. Wade -nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State George Washington Cemetery 7/21/1006 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Lice GM 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Liver Abscess Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year ò Day 4☐Pregnant at time of death 5 Other (specify) P.O. | ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by Diabetes Mellitus; Hypertension 1 ☐ Yes 2 📈No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy rmed? certificete 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death [Check only one] examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 14 Inpatient ၉ 2 ER/Outpatient 3 DOA this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation after death.
Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63343 July 16, 2006 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Irina Yuryevna Ruban, MD 1500 Forest Glen Road Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 18 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Lue Barnes Mattie July 13,2006 10pm /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Fort Washington Fort Washington Hospital If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2√2 F Yrs. S.C Director 249-50-7602 94 08/06/11 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 10a State in than "natural", or flems 23e or 28a-f show the Medical Examiner must be notified at Fort Washington 1⊠Yes 2 No Prince George Md Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20744 525 River Bend Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Maryland 21215-0036 Specify: Black δ 3 Nidowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygiens Important: if liem 27 is marked other the any injury or other traumatic event, the angles. 9th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mattie Moore Solomon Simmons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Daughter 525 River Bend Rd Ft. Washington, Md 20744 Janet Winchester Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Brentwood, Md 07/19/06 Fort Lincoln * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Shead Tuneral Home & Cremation Service 5732 Georgia Ave NW Washington, DC 20011 itiz Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) unknown Physician Acute Respiratory Arrest /Medical Due to (or as a consequence of): Examiner unknown Acute Aspiration Pneumonia Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-transit Physician: The law requires that the death certificate be executed Acute Cerebral Vascular Accident unknown Due to (or as a consequence of): Box 68760, Physician/Medical Advanced Dementia as IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No ō 4□Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ Records, 1 Yes 2 No 3 Probably 4 KUnknown Chronic Anemia Completed Non Insulin Dependent Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas page 1 Yes **2√**□ No certificate Dehydration Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28h Time of 28c. Injury at Work? 27. Manner of Death Certification: After or Attending 1x Natural 5 Pending investigation 1 Tes 2 No death. 2 Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide l in by 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c. License number 29d, Date signed (Month, Dev. Year) 29b. Signature and title of certifie 10 July 14, 2006 D0026262 5 MM completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 11711 Livingston RD Ft. Washington, Md 20744 Kleiman Samuel J. 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature barel State JUL 18 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Mary D. Burbank Julv 16, 2006 8:00 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 10983 Shadow Lane Columbia Howard Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days **Funeral** Min Hours 1 □ M 2 💆 F 1915 90 041 09 8181 6, Connecticut Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County in than "natural", or Itema 23a or 28a-f show the Medical Exerciper must be notified at 1 ☐ Yes 2√2 No MD Columbia Howard Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10983 Shadow Ln. 21044 USA death v Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married 1 Yes 2 No Specify: White Maryland 21215-0036 Specify: Yes. Give þ 3 XWidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education within 72 (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own_Home and Mental Hygier 18. Mother's Name (First, Middle, Maiden Surmame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked can yinjury or other traumatic avo Concetta Costanzo 20 Anthony Deaso 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10983 Shadow Ln. 21044 Bonnie Brownell/daughter Columbia, MD Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 7/17/2006 Metro Crematory Catonsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service License M01442 4112 Old Columbia Pk. Ellicott City, MD orm · Kasa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROPL CARDIOVALCULAR DISEASE **Physician** YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death IF FEMALE: esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? detached for 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 252 No the Hospital or Attending Physician: 26. Place of Death Check on one director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 1 ☐ Yes 2X No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 5 Pending 1 X Natural s after dec. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide determined 4 Homicide o Euneral Dietely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) ertifier 29b. Signature and title of D5-1860 July 17, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAINE # 200 10700 CHANTEL F-15H COCUMB14 JON A MANY MO 32. Pogistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

		Please	Type or Prin							gible.	
		1 - For State Registrar	State of Ma	-		artment of the tificate of	Health and N Death	lental Hy	giene Reg. No.	006	24095
Physic		1. Decedent's Name (First, Middle, Last KATHARINE S		CHAL	4ER	S		2. Date of De Month	Day	Year 2006	3. Time of Death 8:00A.11. M
/Med Exam		4a. Facility Name (If not institution, give REEDER'S NURSING	street and number)			4b. City, Town, C	or Location of Death		4c. Cou	Inty of Death	1
Funera Director		Social Security Number 6. Se		88 Y	rs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 7/25/1	th ay, Year) 1917	9. Birthplace (State or Fo Country) 7 PENNSYLVANIA	
yland yland		Usuaf Residence of Decedent 10a. State 10b. County		10c. City, Town	or Lo	cation					10d. Inside City Limits
he Man	Director	WV BERKELE	Υ	FALL	IN	G WATERS			40.00		1 ☐ Yes 2 🛣 No
h with t	al Dir	10e. Street and Number 41 WEEPING WILLO	W RD.			10f. Zip Code 254	19		10g. Citizen		untry?
lore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heelth and Mentat Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Madical Examinar must be inclified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S.		Vas Decedent of h f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - Amer Black, White Brity: WH	
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d within glene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		OO NOT use retire MEMAK ER	d)		OMV	HOME	
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours at Depertment of Heelih and Mental Hygiene. mportant: if item 27 is marked other than "natural", or my injury or other traumatic event, the Madical Exemptons.	To Be C	17. Father's Name (First, Middle, Last) GEORGE SMYTH					18. Mother's Nam	e (First, Middle IARINE N		,	
and 2 sho leelth and m 27 is m		19a. Informant's Name/Relationship (7)		41	WE	EPING WI	and Number or Rur LLOW ROAD		ING WAT	ERS,	WV 25419
Pages 1 Pages 1 ment of H ant: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)		ARLING O	V N	sition (Name of	JULY 2 2006	25,	ARLING	TON, W	
Baltimo		21. Signature of Funeral Service Licens	Biown		BF	Name and Addre ROWN FUNER	AL HOME, P.(BOX 82 MARTIN	1, 327 W SBURG, W	. KING W 25402	ST.,
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icate be executed physicien and sthe buriel-transit	Icai Examiner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	Jonsequence of		we c	y Disco	tis			
BOX 6 ath certif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetaf death		Ectopic pregnanc Other (specify)	у			Date of delive	very Day Year
Cords, P.O. I wrequires that the de been signed by the a should be detached to	ρ	Part II. Other significant conditions co	mention of the state of the sta	ut not resulting in	the ur	nderlying cause gn	ven in Part I.	23e. Did t			the cause of death?
DIVISION Of VITAI RECORDS, for Attending Physician: The law requires I after death. Director: After this certificate has been signs in by the funeral director, page 2 should be.	Completed		<u> </u>					24a. Was auto perfo		b. Were aut prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of
VITA sician: certific irector,	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatie	nt 2□ER/Out		Ott	26. Place of Deat				
DIVISION Of VITAI Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day			28c. Inju	ner: 4 Nursing Hory at rk?	28d. Describe			fy)
DIVISIO ospital or Attend hours after death uneral Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubulding, etc.	ry - At home, farr :. (Specify)	n, stre	eet, factory, office		28f. Location (. City or To		imber or Rui	al Route Number,
To the Hospital within 24 hours a To the Funeral completely filled	edicai	29a. Certifier (Check only one) 2 Medical Exami	sician: To the best of inar: On the basis of and manner sta	examination and	death /or inv	occurred at the til restigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and date and place	manner as e, and due	stated. to the cause(s)
To t To t	Σ	29b. Signature and title of certifier		7		29c. Licens	1996.		J414	ned (Month	2006
3H-1		30. Name and address of person who co			*	Print)		AND 217	713 3	301-43	2-8470
Si Regis	tate trar	31. Date filed (Month, Day, Year) JUL 2 1 2	32. Registra	ar's Signature		perles	9 10 1111	1	10 0	.J. TJ	

			1- For State of Maryland / Dep	artment of Health and M <i>rtificate of Death</i>	lental Hygien Rag. N	21116 211	96
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of	Death
	Physicia /Medic		Elinor Louise Creel			2006 Year 7:40	Р. м
ß	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death	
			9803-B Fox Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Frederick If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Frederick	r Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 N F 7. Age (In yrs. last birthday,	Months Days Hours Min.	(Month, Day, Yea	9. Birthplace (State of Country) 1914 Maryland	roragn
			Usual Residence of Decedent		sune 10;		
	how de	L	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside Cit 1 ☐ Yes	•
	Be-f	cto	Maryland Frederick Frederick		100 (- 141
	with the	2	10e. Street and Number	10f. Zip Code		Citizen of What Country?	
	heeth me 23	eral	9803-B Fox Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21702 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,	
92	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. important: if item 27 ie marked other then "natural", or iteme 23e or 28e-f ehow eny injury or other treumetic event, the Medical Examiner must be indiffied at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White, etc. Specify:	
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lai	Menta Menta arked	To	Milton Guy Beckley		zabeth Kai		
Maryland	2 shd and ie m			ing Address (Street and Number or Run			
e, r	1 and 1ealth em 27 ther t		Michael R. Beckley, nephew 4256 20a. Method of Disposition 20b. Place of Disp	Briarwood Court,		1, MD 21769 Location - City or Town, State	
Baltimore,	nt of h		1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	ematory or other place)			1
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Ba	Depermine Deperm		10100 100	0 East Antietam_St		•	740
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	Physician	3 3	Immediate Cause (Final disease or condition Cerebrovascular D			Onset and I	Death
	/Medical		resulting in death) Due to (or as a consequence of):	Ibcabe			
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Вох	death certific a attending p d for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery Month Day	Year
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Ď		Certification:	4 Homicide determined building, etc. (Specify)		City or Town, St		
	To the Hospital or within 24 hours ette To the Funeral Dir completely filled in I		29a. Certifier (Check only (Check only 2) Madical Examinar: On the basis of examination and/or	ath occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. and place, and due to the cause(s	5)
	To the within 2 to the formplet	Medical	29b. Signature and title of celtifier	29c. License number	29d.	Date signed (Month, Day, Year)	
	T will		• / / / /	A.)			
			30. Name and address of person who completed cause of death (Item 23a) (Type	@16428	July	7 20, 2006	
3	4-15			nth Street, Freder	ick, Mary	Land 21701	
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Regist	rar	JUL 2 1 2006 Janeer D. 19	pour			

		4	State (irtment of Health and M tificate of Death	ental Hygien	Z11116 / 10119 /
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
ш	Physicia	_	Robert Asa Croft			July 14,	^{рау} Year 4:20 ам
1	/Medic Examin		4a. Facility Name (If not institution, give street and n	umber)	4b. City, Town, or Location of Death		4c. County of Death
	Examin	er	Holy Cross Hospital		Silver Spring		Montgomery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	Birthplace (State or Foreign
	Director		220-28-9893 1X M 2 F	74 Yrs.	Months Days Hours Min.	Dec. 18, 1	
		ļ	Usual Residence of Decedent				
	how Let		10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits 1 ☐ Yes — — No
	Ma-f-	5	Maryland Montgomery	Silver	Spring		
	9r 28	Directo	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Country?
	within 72 hours after death with the Maryland ene. Then "naturel" or flems 23e or 28e-f show the Modical Examiner must be notified at		2206 Badian Drive		20904		USA
	ems	Funeral	Armed I	orces?	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
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anc	buld be i Mental I arked o	Be C	Harvey C. Croft		Naomi	Orndorf	
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygene. In marked other then "natural", or flems 23a or 28a-f show sumatic event, the Modical Examiner must be notified at	7	19a, Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or Rura	al Route Number, City	y or Town, State, Zip Code)
<u>N</u>	d 2 s th an th an trau		Ellen L. Croft/ Wife		Badian Drive, Silv		
a,	1 an Heel em 2		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	Date 20c.	Location - City or Town, State
Baltimore,	ni e ii ii	1 3	1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from		natory or other place) July 1 Zion odist Church Cemetery	7, 2006	
≣	rtme ri		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee				stburg, Maryland
Ba	permit. Pages 1 and 2 should be Department of Health and Menia Important: if I tem 27 is marked any injuty or other traumatic evone.		19/11/ I B	, F	Name and Address of Facility rancis J. Collins 00 University Blvd	Funeral H 1. W. Silv	dome Inc. ver Spring, MD 20901
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			shock, or heart failure. List only one cause or Immediate Cause (Final	each line.			Interval Between Onset and Death
)	Physician /Medical		disease or condition a. Met	astatic Small-	Cell Carcinoma		
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Œ	The lav	Completed				autopsy performed 1 Yes 2 🛣	? death?
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ō			27. Manner of Death 28a. Da	te of Injury onth, Day Year) 28b. Time of Injury	f 28c. Injury at Work?	28d. Describe how in	njury occurred
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á	s afte	Certification:	Thomas Du	iding, etc. (Specify)			
	To the Hospitel or Attend within 24 hours after death To the Funere! Director: completely filled in by the		29a Certifier 1 Certifying Physician: To (Check only 2 Medical Examiner: On the	the best of my knowledge, deal	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause	e(s) and manner as stated.
	he Hi n 24 he Ft	edical		anner stated.			
	Vithi To the	Σ	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
	8+1		~ Ident		D64024	Ju	ly 14, 2006
			30 Name and address of person who completed containing, M.	ause of death (Item 23a) (Type	Print)	er Shring	MD 20910
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		ate	Market of the common of the	Registrar's Signature	autil		
	Regist	rar	90 T (5000	Been Is A			

			For State Registrar	State of Marylan		artment of He tificate of D			giene Rag. No. (2006	24098
			Decedent's Name (First, Middle, Last	0				2. Date of De	ath		3. Time of Death
	Physici		Helen Riley Co	llins				Month July	Day	Year 2006	9:00 a M
1	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	July		ounty of Death	
	CXAIIIII	C1	2006 Van Buren St	treet		Hva	ttsville		Pr	ince G	eorge's
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	9. Birth	place (State or Foreign intry)
	Director		241-22-5733	□ M 2 1 85	Yrs.	Worters Days	710013	Aug. 2			th Carolina
	D .		Usual Residence of Decedent	100 Cit	v. Town or Lo	cation					10d. Inside City Limits
	aryla ehov	_	10a. State 10b. County		,,						1 ☐ Yes 2 🔂 No
	Ne M	Director	Maryland Prince (George's	Hya	ttsville			10g Citize	on of What Cou	intry?
	with t	ā	2006 Van Buren St	troot		20782				USA	,
	99th 9	era	11. Marital Status	12. Was Decedent Ever in U	S 13 1	Was Decedent of His	spanic Origin? (Sp	ecify Yes or No		. Race - Amer	ican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23a or 28a-f show importent: If item 27 is marked other than "netural", or items 23a or 28a-f show injury and items it is marked other than "netural per notified at ance.	by Funeral	1 □ Never Married 2/□ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		fYes, specify Cubar 1 ☐ Yes 2√2 No	Specify:	Rican, etc.)	F	Black, White pecify:Whi	
Maryland 21215-003	2 hou		15. Decedent's Ed		16a. Dece	dent's Usual Occupa	tion	· ina	16b. Kind	d of Business/l	ndustry
7 2	nin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)		kind of work done d DO NOT use retired)		ang			
5	d with	E	12		Secr	etary			Gover	nment	
9	e file al Hy othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden Si	umame)	
<u> </u>	Ments Ments mrked witice	2	Paul M. Riley				Mary Oa	kley			
a	and I		19a. Informant's Name/Relationship (7			ng Address (Street a			•		
Σ.	and and in 27 m 27		James Ignatius Co	•		Van Bure					
Baltimore,	Pages 1 nent of H nr: If ite		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	emetery, crei	sition (Name of matory or other place Memorial	" ¦ Ju	Date 1y 18, 2006		ation - City or 1	Maryland
ati	partur porte y injy		21. Signature et Funeral Service Licen	800	F	Name and Addres					tracy action
<u> </u>	80 5 5 8		* Kukard I An le	2)						Spring	g, MD 20901
п			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not ent	er the mode of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
y	Physician		Immediate Cause (Final disease or condition	Alzheimer's	Diseas	е					10 Years
	/Medical Examiner		resulting in death)	Due to (or as a consec	juence of):						
	Exammer		Sequentially list conditions,	b							
	pe si	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	uence otja						
	and and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	uence of):		_			_	
8760,	icate be executed physicien and s the burial-transit	E III			, , .						
387	phys the	dical		. d							
9 X	death certific e ettending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn	ancy				23	d. Date of deli	verv
Вох	etter etter I for u	ciar	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of c		∃Ectopic pregnancy ∃ Other (specify)				Month	Day Year
o.		lysi	9 Unknown	9□ Unknown							
ds, P	w requires that the sbeen signed by the should be detache	þ	Part II. Dther significant conditions o	ontributing to death but not res	sulting in the u	nderlying cause give	en in Part I.				the cause of death?
of Vital Record	> 11 0	Completed						24a. Was	an	24b. Were au	topsy findings available
Be	e la hes	m C							ormed?	death?	completion of cause of 2 ☐ No
tal	iclan: Th certificate ector, pag	O O	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes		1 103	2 NO
5	Physician: this certific ral director.	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Othe	ar	ome 5 🗹 Res		Other (Spec	cify)
	Men		27. Manner of Death 1 StNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at (? Yes 2 □ No	28d. Describe	how injury	occurred	
Division	Hospital or Attendi 24 hours after death Funeral Director: A stely filled in by the fo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st	reet, factory, office			(Street and wn, State)	Number or Ru	ral Route Number,
	Hospit 24 hours Funeral	edicai (ysician: To the best of my kn ninar: On the basis of examin- and manner stated.							
	To the Horwithin 24 h To the Fur	Me	29b. Signature and title of certifier	211 1		29c. License			29d. Date	signed (Mont!	n, Day, Year)
	20		1/	luco		D24	093		Jul ₂	y 17, 2	2006
			30. Name and address of person who Mark A. Parkhurst			Print) Avenue,	#200, Ri	verdale	, MD :	20737	
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUL 18	32. Bigistrar's Sign	ature /	barde					

06-04846 Please Type or Print in Black Indelible Ink Rose Marie Rawling-Cullins State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Dav Month Year Rose Marie Rawlings Cullins 1203 hrs **Medical Examiner** July 8, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Cheverly Prince George's If Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY 9 Birthplace (State or Foreign Washington, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 578-52-1801 Director Country) DC 1 M 2 X F 67 August 8, Usual Residence of Decedent 10d Inside City Limits 10a State 10b. County 10c. City, Town or Location Yes 2 X No with the Maryland Maryland Calvert Owings Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country 9031 Marcellas Drive 20736 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. Pages 1 and 2 should be filed within 72 hours after death Never Married 2 x Married Yes 3 Widowed 4 f Yes, Give Year Yes 2 X No specify Divorced SpecWhite ð 16a Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Hame 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Bishop L. Rawlings Rosie Lea Hendley 19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mevelyn D. Cullins, Jr./Husband 9031 Marcellas Drive, Owings, Maryland 20736 nt of Health and it. If item 27 20a Method of Disposition 20b Place of Disposition (Name of cemetery, Date 20c Location - City or Town, State Baltimore, crematory or other place! Burial 2 July 14, Cremation 3 Removal from State Gate of Heaven Cemetery Important: injury or oth 2006 Dopation 5 Other Specify Silver Spring, Maryland 21 Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring. M)
complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart MD 20901 Approximate Interva Phil Enter the disease, or **Physician** failure List only one cause on each line Between Onset and /Medical Death Multiple Injuries Immediate Cause (Final disease ™xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical UNPENDED AMENDED requires that the death certificate be Box 68760 23d Date of delivery eattending physical for use as the b 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? o þ σ. 1 Yes 2 V No 3 Probably 4 Completed Records, 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has death? performed? ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) Physician: 25 Was case referred to medical of Vital Be examiner? Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes 2 After 27 Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P Jul 8, 2006 (Month Day, Year) Passenger auto auto collision Natural 1025 hrs 5 Pending Division Yes 2 V No within 24 hours after death To the Fineral Director: the Certificati 2 🗸 Accident Investigation 28f Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide determined To the Hospital (Specify) Major Road / Highway Solomons Island Rd & Mitchells Chance Rd, Edg Homicide 29a Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d Date signed (Month, Day, Year) 29b. O.C.M.E July 9, 2006 30. Name and address of person who complete cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD. State 4 2006 Angelow. Registrar

		1	For Stete Registrar		State of	f Marylan			t of Heal		Mental Hy	/gien	7) (1)	06	241	00
			Decedent's Name (First, Middle	, Last)							2. Date of D	eath			3. Time of Dea	ith
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)	/Medic Examin		4a. Facility Name (If not institution	, give st	reet and nun	nber)		4b. City,	Town, or Loca	ation of Deat	h	40	. County o	f Death		
	Examin	- 1	Renaissance	Ga	rdens			S	ilver	Spri	ng		Mont	gor	nery	
	Funeral		5. Social Security Number	6. Sex		Age (In yrs.	last birthday)	If Unde	r 1 Year If U	Inder 24 Hrs	0.0000 04.0	irth		9. Birthp	tace (State or Fo	reign
	Director		577-01-4536	1 🗆 :	M 2⊠F	89	Yrs.	Months	Days Ho	ours Min.	11/03	/19	16 V	Vasi	n., D.C.	
			Usuel Residence of Decedent													
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	death with the Maryland me 23a or 28a-f ehow r must be trydflied at	Funeral Director	3160 Gracefi	eld	Road	l			20904				US	SA		
	deat	Jer	11, Marital Status	12	2. Was Dece Armed For	dent Ever in U	.S. 13.	Was Dece	dent of Hispar	nic Origin? (S	Specify Yes or N to Rican, etc.)	lo-		- Americ	an Indian,	
0	after or Ite		1 Never Married 2 Marr	ied	1 Yes	2 🔀 No		1 🗆 Yes		ecity:	to rabarr, oter,		Specify:			
2-003p	ral',	þ	3√2 Widowed 4 □ Divorced		If Yes, Giv Year or Da	ates:		10 105	2,80 30	ocity.			эреспу.			
2	72 ho	Completed	15. Deceden (Specify only higher				16a. Dece	dent's Usu	al Occupation	most of wo	rking	16b. i	Kind of Bus	iness/In	dustry	
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N	or th	5	12				Н	omen	aker							
and	al Hy al Hy rent	Be	17. Father's Name (First, Middle,								me (First, Middl		n Surname)		
<u>a</u>	Vid b	٥	Albert Wasko	111						Julia	O'Con	1101				
Mar)	and le me		19a. Informant's Name/Relations				19b. Maili	ng Addres	s (Street and f	Number or R	ural Route Num	ber, City	or Town, S	State, Zip	23188	
Σ	and 2 patth atth er tr		Joseph T.Cor	so/	Son		103	Lin	coins	nire	Willia	IIIISD	urg,	va.	23100	
e e	1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 =		20a. Method of Disposition	a 🗆 🗆 a	maria lana		Place of Disponentery, cre-	osition (Na matory or	me of other place)		Date		ocation - C			
Ĕ	Page III III		1 SpBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	ο ⊔πε βecity) /	in varirom :	Ga	ate o	f He	aven	7/1	4/06	Si	Lver	Spr	ring,Md	
aitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar begetment of Health and Mental Hygiens. Disperment of Health and Mental Hygiens in Integratine! It flow 27 is marked other than "natural", or Items 23s or 28s-f show eny injury or other traumatic event, tra Medical Examinar must be mutified at once.		21. Signature of Juneral Service	Licers	N		2	2. Name a	nd Address of	Facility	I FUNE	RAT	SERV	JT CE	E.P.A.	
ñ	P P P P		NILL K	Line	6			241	Columb	oia B	lvd.Si	lve	Spi	ring	,Md209	10
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	Dhysisian		shock, or heart failure. List Immediate Cause (Final	Orny Orne			Comai	noma							Onset and Deat	
	Physician /Medical		disease or condition resulting in death)	_ a.		adder		.1101116	L .						1 1110	
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		<u>-</u>	Sequentially list conditions,	b.	b. Due to (or as a consequence of):											
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	ding se a	an/Me	IF FEMALE:	23	c. If yes, out	come of pregn	ancy						23d. Date	of deliv	arv	
X Q R	death e atter	lar	23b. Was decedent pregnant in the past 12 months?			oirth 2 Feta		⊒Ectopic p ⊒ Other (s					Mon		Day Year	
j	the d	Physicia	1 □ Yes 2 □ No 9 □ Unknown		9□ Unkno			_ 0 (0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
7.	law requires that the death certifica as been signed by the attending pl 2 should be detached for use as t	유	Part II. Other significant conditi	ons cont	ributing to de	eath but not res	sulting in the u	inderlying	cause given in	Part I.	23e. Did	tobacco	use contril	bute to t	he cause of death	1?
ecords,	signe signe d be	þ						, -			10	Yes 2	2 🔯 No :	3 🗆 Prot	ably 4 Unkr	nown
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<u> </u>	Page 1	Cor									1 ☐ Yes			Yes	2□ No	
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Division of	ding P h. After t funera	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	na	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury		28c. Injury at Work?		28d. Describe	how inj	ury occurre	ed	TT A T11	9
000	itendi death. tor: A the fu	Certification:	2 Accident investi	gation				М	1 🗌 Yes	2 🗆 No						
ž	of or Attency after death	ij.	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ			of Injury - At h ing, etc. (Speci		reet, facto	ry, office		28f. Location City or T	(Street a own, Sta	ind Numbe te)	r or Rur	al Route Number,	
	spital or ours afte neral Dir filled in	Cer			1											
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 ☐ Certifyin (Check only 2 ☐ Medical	ng Phys Exemin	icien: To the	best of my kn	owledge, dea	th occurre	d at the time, d	ate and plac	e, and due to th urred at the time	e cause(s) and man	ner as s	tated. o the cause(s)	
	in 24 in 24 in 8 F	edical	one)		and man	ner stated.										
	To t	Σ	29b. Signature and title of certific	1	1	1			c. License nui			29d. D	ate signed	(Mogth,	Day, Year)	
)	Q		Muals	Me	1841				00043	375			7/11	100	5	
	0		30. Name and address of person	who cor	mpleted caus	se of death (Ite	m 23a) (Type	, Print)			a .		7 20	004		
			Karén Merri							TIVer	Sprin	19,M	u 20	204		
	Sta		31. Date filed (Month, Day, Year,	A 30	49	egistrar's Sign	ature	CBARL								
	Registi	ar	. 1111.	4 20	JUUL A	Profession.	1									

	•	For State Registrar	State of Maryland		ite of Death		Reg. No.	4910
Physicia		1. Decedent's Name (First, Middle, Last) Ann Sarah Cohn				2. Date of De Month July 12	Day Year	3. Time of Death 4:42 P
/Medic Examin		4a. Facility Name (If not institution, give s Washington Adventi		l l	y, Town, or Location of I coma Park	Death	4c. County of Dea	
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last 93		ber 1 Year If Under 24 s Days Hours	Min. 8. Date of Bir (Month, Da Nov • 2	9. Bir 8, 1912Balt	thplace (State or Foreig ountry) Limore, MD
ehow d at	٥٦	Usual Residence of Decedent 10a. State 10b. County		own or Location				10d. Inside City Limits
a or 28a-1 be notifie	Directo	MD Montgomer 10e. Street and Number 1121 University Blv			Tip Code 0902		10g. Citizen of What C	ountry?
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director		2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was De	cedent of Hispanic Origin becify Cuban, Mexican, I 2XI No Specify:	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Am Black, Whi Specify: WI	te, etc.
ne. han "natura a Medical E	Completed	15. Decedent's Educ (Specify only highest grade	completed) College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NOT	work done during most o "use retired)	of working	16b. Kind of Business	
ental Hygie ced other t c event, th	To Be Co	12 17. Father's Name (First, Middle, Last) Hyman Tabb		roperty	18. Mother's	s Name (First, Middle a Becker		
olth and Me 27 is mark r traumati	Ĕ	19a. Informant's Name/Relationship (<i>Tyj</i> Ned M. Cohn – So		19b. Mailing Addre	ess (Street and Number shead Drive	or Rural Route Numb Bridgewat	er, City or Town, State, er, NJ 0880	Zip Code))7
Int: If item		20a. Method of Disposition 1½ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State	e of Disposition (fletery, crematory can Mem.	Gardens 17-	Date -14 - 06	20c. Location - City o	
Departn Imports any inju		21. Signature of Fureral Service License		1170	Rockville I	Pike Rockv	ille, MD 20	852 Approximate
physicien and sice and street	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer Due to (or as a consequer Due to (or as a consequer	mce of):	cardial			Interval Between Onset and Death
been signed by the attending p should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal do 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 □Ectopi	c pregnancy (specify)		23d. Date of d Month	elivery Day Year
n signed by uld be deta	þ	Part II. Other significant conditions con	tributing to death but not resulti	ing in the underlyin	g cause given in Part I.		tobacco use contribute Yes 2 □ No 3 □ F	1/
certificete has bee irector, page 2 sho	Completed					1 □ Yes	opsy prior to death?	autopsy findings availa completion of cause is 2 \(\sum \text{No} \)
fter this	on: To Be	27. Manner of Death		R/Outpatient 3 Bb. Time of Injury	DOA Other: 4 Nurse	28d. Describe	idence 6 Other (Sp	ecify)
deat ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	M ne, farm, street, fac	1 Yes 2 N	28f. Location	(Street and Number or I own, State)	Rural Route Number,
within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medicai C	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best of my knowl ner: On the basis of examinatio and manner stated.	ledge, death occur on and/or investiga	red at the time, date and tion, in my opinion, death	place, and due to the n occurred at the time	, date and place, and de	ue to the cause(s)
Within 2 To the Complet	Me	29b. Signature and title of certifier			29c. License number 4036)	July 13	
1		30. Name and address of person who co	ompleted cause of death (Item 2	23a) (Type, Print)	CICIPA	700 51	S. S. M.	1. 120

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Morris COHEN July 11, 2006 11:24 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Director 90 Aug. 5, 1915 148-05-1196 New York Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits rthan "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3310 N. Leisure World Blvd. #102 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. I important: If Item 27 is marked other than "natural", or Item any injury or other traumatic avant, the Medical Examinat one. Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo white Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Author U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Surname) Isador Cohen Leah Ruth (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a, Informant's Name/Relationship (Type, Print) Louise Goldstein, Wife 3310 N. Leisure World Blvd. #102, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lebanon Cemetery 07/13/06 Mt. Adelphi, MD 21. Signature of Furieral Service Ligensee 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Dea Immediate Cause (Final disease or condition resulting in death) Septic Shock **Physician** /Medical Due to (or as a consequence of): Examiner 3 Days Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Urinary Tract Infection 3 Davs Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the etter 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? To the Hospital or Attending Physicien: within 24 hours after death.
To the Funerel Director: After this certifies Be funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Natural Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0.64444 July 11, 2006 as gral 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arijit Dasgupta, M.D., 9901 Medical Center Drive, Rockville, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 14 2006 Registrar

		1	1- For State of Maryland / Department of Health and Certificate of Death		iene 006 24103
			Decedent's Name (First, Middle, Last)	2. Date of Dea Month	th 3. Time of Death
	Physicia		JOSEPHINE M DEAFENBAUGH	07	14- 2006 19:30 M
	/Medic Examin	er '	4a. Facility Name (If not institution, give street and number) CALVERT MEMORIAL HOSPITAL PRINCE FRED		4c. County of Death
	Funeral		5. Social Security Number 6. Sex 1 Months Days Hours Mir	8. Date of Birth (Month, Day	9. Birthplace (State or Foreign Country) North Carolina
	Director		Usual Residence of Decedent	Dec. 10	77 1313 1102 61 06201214
	yland		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	a-fs	cto	Maryland Calvert Solomons		1 ☐ Yes 2 X No
	or 28	Olre	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Country?
	ath w	ra	11750 Asbury Circle 20688	(Coosity Voc or No	United States 14. Race - American Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 Ia marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evaluation must be indiffed at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes, Specify Cuban, Mexican, Pus 14. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pus 15. Widowed 4 Divorced 16. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pus 17. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pus 18. Was Decedent of Hispanic Origin?	arto Rican, etc.)	Specify: White
Ş	tural E	ed	15. Decedent's Education 16a. Decedent's Usual Occupation	40	16b. Kind of Business/Industry
Maryland 21215-0036	within 72 ene. than "ne he Medit	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 (Give kind of work done during most of with life. DO NOT use retired) Housewife	rorking	Homemaker
d 2	at Hygie other vent, I		17. Father's Name (First, Middle, Last) 18. Mother's N	ame (First, Middle,	Maiden Sumame)
<u>a</u>	2 should be i and Mentat I la marked of raumatic eve	To Be	Ellis Lee Miller Dora S	Shouse	
ary	shou and N a mai	_	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or it		
	1 and 2 Health a tem 27 la		Ruth Ann Davis- daughter 2110 Park Chesapeake		
ore	of He		20a. Method of Disposition 1 Burial Cremation 3 Removal from State	Date	20c. Location - City or Town, State
Ë	Pages ment of thant: If ite		'4 Donation 5 Other (Specify)	7/17/06	Alexandria, Virginia
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility R 4405 Broomes Island R	Rausch Fur Road, Port R	meral Home, P.A. epublic, Maryland 20676
	*		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	iac or respiratory arr	rest, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition ANOXIC ENCEPHALOPATHY		Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):		
h	Examiner		Sequentially list conditions. b. UROSEPSIS		
	p ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		
	and and I-trans	Examine	Cause (Disease or injury that initiated events c	·	
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687	ate phy:	edical	d.		
Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Hospital Company 5 □ Other (specify)		23d. Date of delivery Month Day Year
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Records, P	uires that signed t Id be deta	by	Part II. Dated agrithment contributing to down but not rooming in the anderlying datase growth at the		bacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
COL	w require been signature should t	Completed		24a. Was a	
Re	The law	шо		- autop perfor 1 ☐ Yes	med? death? 2 No 1 Yes 2 No
Vital	ician: Th certificate rector, pag	O	25. Was case referred to medical 26. Place of D	Death (Check only or	
of V	Physician: this certificatal director, I	To B	1 Tyes 2 Tylo Pospital: 1 Tylopatient 2 ER/Outpatient 3 DOA Galer. 4 Nursing	g Home 5 ☐ Resid	lence 6 Other (Specify)
o uoi	nding Pt tth. :: After the e funeral			28d. Describe h	ow injury occurred
Division	l or Attendii after death. Director: A I in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number or Rural Route Number, In, State)
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C			
	Fo the	Me	200.09		29d. Date signed (Month, Day, Year)
	F > F 0		1 5. Dua MD D00 604	145	07-14-06
	10	Victoria de la companya de la compan	30 Name and address of person who completed cause of death (Item 23a) (Type, Print)		CK, MD-20678
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Fleet Kenneth Edward July 16, 2006 11:50a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral 1XX**M 2□ F Yrs. 578-48-1158 68 18, 1937 Washington, Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Mode 10b. County in than "natural", or itema 23a or 28a-f ahov the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #324 20657 U.S.A. Appeal 50 Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₹ No If Yes, Give ₹ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " College (1-4or 5+) Elementary/Secondary (0-12) taxicab driver transportation 10 other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any loury or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henderson Frances Eleanor Fleet Charles Bruin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 50 Appeal Ln., # 324, Lusby, MD 20657 Dorothy C. Fleet, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remoyal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 7-21-2006 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. Sometime of Funeral Service Licens 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the ris lase, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final-disease or condition resulting in death) Sephc Shock.

Due to (or as a cinsequence of): Physician May 5 /Medical Congestive healt faily 52 Examiner 17475 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o. as a consequence of): Examine and fail 102. 13645. ettending physicien and for use as the burial-transit hnnic Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Didates nellinis uncullanced 1 Yes 2 No 3 Probably 4 Unknown Completed valental dillase Din she sail 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete has 1cme a amyutabon Below 1 Yes 2 No of Vital 25. Was case referred to medical funeral director Be 26. Place of Death Check only one examiner? Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဥ this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After Division Just or Att.

Turs after dean

I Director: Att.
in by the fire 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061719 Jul 17 2006

State Registrar 31. Date filed (Month, Day, Year)

JUL 1 9 2006

DHMH 17 Rev 1/2001

Dhananjay V. Bhavsar, M.D., 24035 Three Notch Rd., Hollywood, MD 20636

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

		1	For State Registrar	State of N	Maryland		artment of H		ind Menta	l Hygie	ZUUI	5 24105
	التحال		Decedent's Name (First, Middle, I	Last)						e of Death		3. Time of Death
	Physici: /Medic		Harvey James	Ferris					Jul	y 16,	ີ2006 ^{ເຄ}	7:30 A. M
	Examin		4a. Facility Name (If not institution, g				4b. City, Town, or		f Death		4c. County of D	
			Asbury-Solomons		JIVING Age (In yrs. Ia		r Solome		4 Hrs R Date	e of Birth	Calver	Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 6 163–03–5377	.Sex 1 M 2 □ F	89 (III yis. ia	Yrs.	Months Days	Hours	Min. (Mo	nth, Day, Yi	1917 N	Country) ew Jersey
			Usual Residence of Decedent						1 2			
	ahow ahow		10a. State 10b. County			Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes ※☐ No
	8a-1 s	Director	Maryland Calver	t	Solo	omons	T			40.		
	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or frems 23a or 28a-f show marked other than "natural", or frems 23a or 28a-f show marked other than "nature".	Ο̈́	10e. Street and Number 11750 Asbury Cir	cle #101			10f. Zip Code 20688				Citizen of What	•
	heath	Funerai	11. Marital Status	12. Was Deceder		3. 13. V	Was Decedent of H	lispanic Orig	gin? (Specify Ye	s or No-		American Indian,
0	after o	Fun	1 Never Married 2 Married	Armed Force 1 Yes 2[If Yes, Give		'	f Yes, specify Cuba	an, Mexican,	, Puerto Rican, e	etc.)		Vhite, etc.
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Maryland 21215-0036	2 should have larmana		19a. Informant's Name/Relationship				g Address (Street				-	
	1 and 2 Health tem 27 l	1	James H. Ferris	(Son)			Martha's	Way,		-		
altimore,		l i	20a. Method of Disposition 1 ☐ Burial 2X Cremation 3	☐Removal from Sta	C 0	ace of Dispo metery, cren	sition (Name of natory or other plac	сө)	Date	20	c. Location - City	or Town, State
Ē	tmen tmen tant:		'4 □ Donation 5 □ Other (Spe		Met	repel	itan Cre	natory	7,7/17/0	6 Al	exandria	a, Virginia P.A.
Ba	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lic	censee								, P.A. aryland 20676
			23a. Part1. Enter the disease, or co	omplications that caus	ed the death.						······	Approximate
J			shock, or heart failure. List or Immediate Cause (Final	ly one cause on each	line.							Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	as a conseque	ence of):	INFA.	RET	00~			MINUTES
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	and and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.								
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687	phys s the	edicai		d.								
×	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor							23d. Date of	delivery
m	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant]Ectopic pregnancy] Other (s <i>pecify)</i>	′			Month	Day Year
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	res tha igned be det	by F	Part II. Other significant condition:	s contributing to death	but not resul	lting in the u	nderlying cause giv	en in Part I.	23			e to the cause of death? Probably 4 Unknown
ord	w require been si	ted								1 L Yes	2□No 3□	Probably 4. Unknown
Records,	has by	Completed							24:	 a. Was an autopsy performer 	prior	autopsy findings available to completion of cause of
	(d) man									Yes 2		Yes 2□ No
Vita	Physician: Th r this certificate ral director, pag	Be c	25. Was case referred to medical examiner?	Hospital:			• 3C DOA Oth		of Death (Check		0.50	2
o	Phys or this aral di	. To	1 ☐ Yes 2 ☐ 400 27. Manner of Death	28a, Date of I	itient 2 🗆 E	28b. Time of	28c. Injur	y at			e 6 Other (5	Specify)
ion	Attending I r death. ector: After by the funer	atio	1 ☐ Hatural 5 ☐ Pending 2 ☐ Accident investiga		Day Year)	Injury	Wor M 1 □	k? Yes 2 □ N	No			
Division of	or Attendi after death. Director: A	Certification:	3 Suicide 6 Could no determine	288. Place of	Injury - At hor etc. (Specify)	me, farm, str	eet, factory, office			ation (Stree		r Rural Route Number,
Ö	ital or rs afte al Diu	Cer		1							,	
	To the Hospital or Attending Physician: within 24 horus after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medicai	(Check only 2 Medical Ex	Physician: To the be caminer: On the basis	of examinati	vledge, death ion and/or inv	occurred at the tirvestigation, in my o	ne, date and pinion, deat	d place, and due h occurred at th	to the caus e time, date	e(s) and manne and place, and	r as stated. due to the cause(s)
	thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner	stated.		29c. Licens	e number		29d.	Date signed (M	onth, Day, Year)
1	F 3 F 8		NI	06-1				. 758	•	7	-UL × 1	7 2006
,			30. Name an ress of person wi	no completed cause of	f death (Item	23a) (Type.		330			/ (, 0000
1	1+08	. 3	John H. Weigel,				-), Pri	nce Fre	deric	. Marvl	and 20678
	Sta		31. Date filed (Month, Day, Year)	#32. Regi	strar's Signati	ure						
	Regist	rar	JUL 1 9 200	6 Bergie	N.	Good						

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漱	Physicia	400	1. Decedent's Name (First, Middle, Last) Fred Feldman							Date of Dea Month uly	Day	2006	3. Time of Death 4:35P M
	/Medic Examin		4a. Facility Name (If not institution, give s. Manor Care Potomac	treet and number)		4	b. City, Town, or Potomac	Location of	Death			unty of Death tgomer	У
	Funeral Director		5. Social Security Number 6. Sex 577-07-9959	M 2□F 7. Ag	ge (In yrs. last bir 97		If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day)	Year)	9. Birthp Coun Russ	tace (State or Foreign try) 1a
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	or 28a	Direc	10e. Street and Number		1 O COME		10f. Zip Code			1		of What Coun	try?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show among 10 montal transportant in the Maryland Inchinated an Approximation of the Maryland Inchination and Approximation of the Maryland Inchination of the Maryland Inchinati	d by Funeral Director	1 Never Married 2 Married 3 ₺ Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	No	1 C	20854 s Decedent of His es, specify Cubar Yes 28 No	Specify:	in? (Specif Puerto Ric	y Yes or No- can, etc.)	Spi	Race - Americ Black, White, e ecify: Whit	e e
Baltimore, Maryland 21215-0036	d within 72 h giene. ir than "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		5+)	(Give kın life. DO	nt's Usual Occupa nd of work done d NOT use retired) r/Liquor	uring most			Reta	of Business/ind	dustry
land	uld be file Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Sam Feldman						rsName (F Lie Ko	First, Middle, oker	Maiden Sur	name)	
, Mary	and 2 sho alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Type Melvin Feldman- So		19b	b. Mailing /	Address <i>(Street</i> a Lamppost	nd Number Lane	r or Rural R Poto	omac, M	r, City or To 1D 208	wn, State, Zip 54	Code)
more	Pages 1 and of He int: If item		20a. Method of Disposition 1 Burial 2 □ Cremation 3 R 4 □ Donation 5 Other (Specify)	emoval from State		David	ion (Name of tory or other place Memoria	a1 7	Date 7-16-0	06	Falls	on - City or To Church	, VA
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service License	е			Name and Addres						irection 2
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Division	al or Attences after death	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of fn building, e	jury - At home, fa tc. (Specify)	arm, street	t, factory, office		281	f. Location (S City or Tow	treet and N n, State)	umber or Rura	l Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 区 Certifying Phys (Check only one) 2 ☐ Medical Examin		of examination ar								
	To the P within 24 To the F complete	Ž	29b. Signature and title of certifier	2205			29c. License	number		2	29d. Date si	gned (Month,	Day, Year)
r	V		30. Name and address of person who co						0.100		7-13-	06	
	Sta	ate [§]	Sunitha Bhogavilli 31. Date filed (Month, Day, Year)	1220 A	East Jo	ppa R	d. Tows	on, MI	D Z1Z	00			
	Registi		31. Date filed (Month, Day, Year) JUL 1 4 20	06	ie St.	Goa	NEW YORK						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 tem 2 per doc 858 8-1-06 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) Dav JULY Year **Physician** MAUREEN ELVA GROVE JUNE 2006 3:24am /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CIVISTA MEDICAL CENTER LA PLATA CHARLES 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Min. Months Hours 1 □ M 2X□X€ 71 Director APR.11,1935 WASH., D.C. 578-46-2507 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a_State 10b. County or then "natural", or Iteme 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2/□XNo Director LA PLATA CHARLES MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20646 U.S.A. 9307 WINKLER LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned 1 ☐ Yes 2X No Specify: Specify: WHITE If Yes, Give Year or Dates: þ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Complet permit. Pages 1 and 2 should be titled within Department of Health and Mental Hygiene importent; if item 27 is marked other then eny injury or other traumatic mans. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HOFFMAN HARRY EDWIN BROWN, SR. MILDRED CATHERINE ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9307 WINKLER LANE, LA PLATA, MARYLAND 20646 CYNTHIA PAYNE-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARTINGTON NATIONAL CEM. 8-2-06 ARLINGTON, VA 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licensee M00479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. U 20646 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PEPSIS Physician /Medical Due to (or as a consequence of): Examiner foot gannen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ue to (or as a consequent of): Examine certificate be executed use as the burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Box 68760 Ca of unknown Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, should be d à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 X No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death, 2 Accident investigation Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerel Dire o the Hospital 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 18/06 D-0057999 address of person who completed cause of death (Item 23a) (Type, Print) CHA J. JARIWALA MD 11637 TERRACE DRIVE STE 103 WALDORF MARYLAND 20602 MANISHA J. JARIWALA MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

		•	1 = For State Registrar	State of Marylan			of Health			iene	106	24108
	Dhusiai		1. Decedent's Name (First, Middle, Last)		-				2. Date of Dear Month	th Day	Year	3. Time of Death
	Physicia /Medic	al .		ginia Gue				15 11	July	15,	2006	10:50P M
	Examin	er	4a. Facility Name (If not institution, give st				Town, or Location	of Death			ity of Death	
	Funeral		4001 Cornfield Dr 5. Social Security Number 6. Sex		last birthday)	If Under			8. Date of Birth		derick 9. Birthp	ace (State or Foreign
П	Director		217-28-7468	^{M 2} √2 F 75	Yrs.	Months	Days Hours	Min,	(Month, Day, Dec. 25	, 1930	Mary	yland
	pu .		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	Aaryla r sho	٥	Maryland Frederick		Monrov							1 □ Yes 2√2 No
	28a-	rect	10e. Street and Number		1011101	10f. Zip	Code		1	0g. Citizen o	f What Coun	
	hours after death with the Maryland turel', or Iteme 23e or 28e-f ehow at Examinat must be motified at	by Funeral Director	4001 Cornfield Dr	rive			21770			U.	S.A.	
	deat	ner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Deced	ent of Hispanic Or ify Cuban, Mexica	rigin? (Spe	cify Yes or No- Rican, etc.)		ace - Americ	
36	s after	y Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give	4	1 ☐ Yes 2				Spec	ih.	ite
21215-0036	hour ture!	ed b	15. Decedent's Educ	Year or Dates:	16a. Dece	dent's Usua	I Occupation			16b. Kind of		
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212	d within giene. er than	E O	9th	Onlege (1740) 37)	Hom	emakeı					Home	
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οr	sages ent of nt: If in		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Denation 5 ☐ Other (Specify)	emoval from State	cemetery, cres sthave:			rdens	7/20/0	6 Fre	derick	, Maryland
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot		21. Signature of Funeral Service License				d Address of Facil					
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Œ		Con	PVD						perfor		death? 1 ☐ Yes	
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	To the I within 2. To the I complete	Med	29b. Signature and title of centries	and manner stated.		290	. License number	,	1 2	9d. Date sig	ned (Month	Day Year)
1	Z × Z		JAN V	IN	1	T	200 UL	Na		7/1	7/7	001
7	5		30. Name and address of person who co	ombleted cause of death (Itel	m/23a) (Tyne	Print)	UUTO	UT	0	1//	1/6	000
	•)		Hope McIntyre, 1	M.D. Parkvi	ew Med		Center,	Mount	Airy,	Maryal	nd 2	1771
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	Regist	rar	JUL 1 9 20	JUD OUL	- 7	100						

			1 - For State Registrar	State of Maryland		irtment of H		-	giene Reg. No. 200	6 24109
			Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death
	Physici /Medio		JANE LEE	HYLAND				JULY	14 200	06 1:18 A M
	Examir	- 1	4a. Facility Name (If not institution, give st. CASEY HOUSE-6001 MU		ROAD	4b. City, Town, or ROCK	Location of Deat	h	4c. County of E MONTGO	
	Funeral Director		5. Social Security Number 6. Sex 214-46-6402	7. Age (In yrs. I.	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		y, Year)	Birthplace (State or Foreign Country) ashington, D.C.
7	B >		Usual Residence of Decedent	100 Cib.	. Town or Lo					
-	shoy	5	Md. Montgom	1	ensingt					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
-	28a-1	Director	10e. Street and Number	ici y		10f. Zip Code			10g. Citizen of Wha	
-	death with the maryland ms 23a or 28a-f show r must be notified at		4016 Byrd Road			10 Z.p 0000	20895		United S	•
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36	nours after tural', or ite	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Yes, specify Cuba	Specify:	to rican, etc.)	Specify:	White, etc. White
1215-0036	inour le la	ed t	15. Decedent's Educa		16a. Deced	ent's Usual Occupa	ition		16b. Kind of Busine	ess/Industry
ر 15	within 72 ene. then "na ne Medic	piet	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done of OO NOT use retired	furing most of wor	rking		·
717	giene en et r	Completed	12	2	Med:	ia Assist	ant		Public	Schools
_	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene is not little 23a or 28a-f show any injury of other traumatic event, its Medical Examination matter collider at page.	To Be	17. Father's Name (First, Middle, Last) Harold R. Carls	son, Sr.				me (First, Middle, ueline	Maiden Sumame) Ruddach	
	id 2 should lith and Meni		19a. Informant's Name/Relationship (Type Edward V. Hyland			g Address (Street a Byrd Roa			er, City or Town, Sta Maryland	te, <i>Zip C</i> ode) 20895
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ds,	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions conti	ributing to death but not resu	ilting in the ur	nderlying cause give	en in Part I.			te to the cause of death? Probably 4 @Unknown
CO	w require been si	iete						24a. Was	an 24b. Were	autopsy findings available
Division of Vital Records,	s certificete has t lirector, page 2 s	Completed						autop	osy prior deat	e autopsy findings available to completion of cause of h? Yes 2 \(\sum \) No
<u> </u>	etor, p	BeC	25. Was case referred to medical examiner?					ath (Check only o	one)	
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	within 2 To the	X	29b. Signature and title of certifier		A. L	29c. License			29d. Date signed (M	
•	15		30. Name and address of person who con	noleted cause of death /item	23a) (Type		35635		ח אחחת	5, 2006
			JOSEPH KAPLAN, M	.D. 6001	MUNCA	STER MILI	RD.,	ROCKVILL	E, MD.	20855
2	Sta Registi		31. Date filed (Month, Day, Year) JUL 17 200	37 Registrar's Signar	ture of the	de				

		1	For State Registrar	State of	Marylan		artment tificate			d Menta	Hygie Reg.	the the said		21.1	10
(A	Physici	_	1. Decedent's Name (First, Midd.	e, Last)				PER		Mor	of Death	Day Yea		Time of	
	/Medic Examin	al	4a. Facility Name (If not institutio				4b. City, To	own, or Lo			-9 1	4c. County of De			
	Funeral Director	**	JOHNS HOPKINS 5. Social Security Number 025-38-2456		7. Age (In yrs. i	last birthday) Yrs.	If Under 1	Year If	Under 24 H	Irs. 8. Date In. (Moi	of Birth 1th, Day, Ye H 11, 1		Country)	SETTS	r Foreign
	72 hours after death with the Maryland insturef; or iteme 23s or 28s-f show disal Examinat main be inclined at	Director	Usual Residence of Decedent	ŒRY		y, Town or Lo	10f. Zip C				10g.	Citizen of What		Inside Cit	
215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other then "naturef, or iteme 23a or 28a-f ehow or other traumatic event, The Madical Examinic must be instilled at	d by Funeral	7004 GREENTREE ROA 11. Marital Status 1 □ Never Married 2 ☑ Mai 3 □ Widowed 4 □ Divorced	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2 [X No		Was Decede	nt of Hispa y Cuban, M	Mexican, Pu	(Specify Yearto Rican, e	itc.)	14. Race - Al Black, W	hite, etc.		
21215-	filed within 72 it Hygiene. Ither then "nat	Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed) College (1		(Give	kind of work DO NOT use	done durii retired)	ng most of			LAW	33/11/0/3	ir y	
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	es 1 and 2 sh of Health and of Health and if item 27 is m or other traum		19a. Informant's Name/Relation CANDACE J. KALLER, 20a. Method of Disposition 1 ፟፟፟ 1 ඎ 1 ☑ Burial 2 ☐ Cremation	/WIFE	1 0	1	REENTRE	E ROAI		ESDA, M	ARYLANI	ity or Town, State 20817 c. Location - City			
Baltimore,	permit. Pages Department of I Important: If it any Injury or o		4 Donation 5 Other (2) 21. Signature of Funeral Service	Specify)	MEN	ORAH GAF 22 HJ 11	2. Name and	Address of ALDI I HAMPS	of Facility	16/2006 HOME, VENUE		SPRING, M			904
	Physician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause on e	aused the beat ach line.	h. Do not en							Ar	pproximate terval Bette nset and to	e ween Death
8760,	centricate be executed xauding physicien and ise as the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	EVERE (or as a conseq (or as a conseq	uanca of): 1ELO G	EUS ENOU.	s Lé	UKŁ	MIA			-	Mon	
P.O. Box 68	death certifi e attending (id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live t	tcome of pregna pirth 2 Feta nant at time of down	death 3	⊒Ectopic pre ⊒ Other (spe					23d. Date of Month	delivery Da	y 1	/ear
	Se 50 60	þ	Part II. Other significant condit	ions contributing to d	eath but not res	ulting in the u	inderlying ca	use given i	in Part I.	23	e. Did tobac	cco use contribute 2 No 3 □	Probabl		leath? Jnknown
Reco	The law ate has b page 2 st	Completed		3 de 70 T 4774						-	a. Was an autopsy performe Yes 2		autopsy to compl '? 'es 2[available ause of
Division of Vital Records,	Attending Physician: Thridath. r death. ector: After this certificate by the funeral director, pag	To Be	25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend inves 2 Accident	Hospital:	Inpatient 2 Conjury of Injury (th, Day Year)	ER/Outpatie 28b. Time of Injury		Other: c. Injury al Work?	4 🗌 Nursir	-	Residenc	ce 6 Other (S	(pecify)		
Divisi	Hospitet or Attendi A hours after death. Funeral Director: A etaly filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Coule	not be mined 28e. Place build	of Injury - At h	ome, farm, st	reet, factory,	office		28f. Loc Cit	cation (Streety or Town,	et and Number of State)	Rural R	oute Num	ber,
	To the Hospitel or Atta within 24 hours after de To the Funerel Directo completely filled in by th	edical C		ing Physician: To the Il Examiner: On the b and mar											;)
	O To the within 2 To the comple	Me	29b. Signature and title of certif	('	us			License n	umber			Date signed (M			حاد
Ì			30. Name and address of person DAVIS COSCIDUE,	JOHNS HOPK	ins Hosp	ITUL, E	20 NO2	T4 WO	LAE STI	nser, B.	ILTMOR	E, MARYL	ans,	212	87
	St Regist	ate trar	31. Date filed (Month, Day, Yea JUL 1	7 2006	Registrar's Sign	St. A	radio								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day William Karl Heineman 2006 5:00 July 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Germantown 14416 Brookmead Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. (Month, Day, Year)
April 8, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Months 108-30-5699 New York Yrs 1937 69 Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Germantown 1 ☐ Yes 2 No Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 14416 Brookmead Drive 20874 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Federal Bureau of College (1-4or 5+) 5+ Elementary/Secondary (0-12) Investigation Agent 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) DeNeiri Louis Daniel Heineman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14416 Brookmead Drive, Germantown, MD 20874 Elizabeth M. Heineman/ Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition July 17. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan 2006 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Crematory DeVol Funeral Home, 22. Name and Address of Facility Signature of Funeral Service Licen 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Dysrythmia Due to (or as a consequence of) Due to or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

attending physicien and for use as the burial-transit

detached

sate has been signed page 2 should be detent

certificate has

this After thi

efter death. I Director: Aft d in by the fur

To the Hospinson within 24 hours efter deaf

To the Funeral Director

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director,

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O.

Box 68760,

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

f Health and Mental Hygiene. Item 27 is marked other then "netural", or Iteme 23a or 28a-1 shov other traumatic event, the Medical Examinan must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural; or item any injury or other traumatic event, the Medical State.

Completed by Funeral Director

Be

P

Examiner

Be Completed by Physician/Medical

Certification: To

Medical

2 Accident

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

death with the Maryland

Sequentially list conditions, any leading orimmedial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖄 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending investigation 1 Natural

Other: 4 Nursing Home 5 \$\ Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

28b. Time of Injury 1 ☐ Yes 2 ☐ No

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D20148

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

July 17, 2006

2 X No

(Check only one) and manner stated. 29b. Signature and title of perifier

JUL 18 2006

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

1 ☐ Yes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

911 Russell Avenue, Gaithersburg, Maryland 20877 Stevn Dolinsky, M.D.

Registrar

32 Registrar's Signature

		-	For State Registrar	State of Marylar	nd / Depa		Health and	Mental Hyg	_	6 24113
	Physici /Medic	al -	1. Decedent's Name (First, Middle, Last) Barbara J. Hicke					2. Date of Dea Month July	4, 20°C	
	Examin Funeral	e i	4a. Facility Name (If not institution, give s Holy Cross Rehabi 5. Social Security Number 6. Sex	litation Cent		Burton If Under 1 Ye				comery Birthplace (State or Foreign
	Director	-	034-22-5296 1□ Usual Residence of Decedent 10a. State 10b. County		77 Yrs.	Months Da	ys Hours Mir	8. Date of Birth Dec . 13,	1928 Ma	assachusetts 10d. Inside City Limits
	the Maryle r 28a-f sho	rector	Maryland Prince Ge		ltsvill		e	1	log, Citizen of What	1 ☐ Yes 2 No
	e 23a or	eral Di	3207 Dunnington Ro	ad 12. Was Decedent Ever in t	10 13		20705	Specify Yes or No.	United	States
9036	be filed within 72 hours after deeth with the Maryland nat Hygliene. do other then *neturel', or Iteme 23a or 28a-f show event, the Medical Examinal must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify C		Specify Yes or No- into Rican, etc.)	Black, W	White, etc. White
215-0	nin 72 h	Completed	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Oc kind of work do DO NOT use re	cupation ne during most of w tired)	orking	16b. Kind of Busine	ess/Industry
1212	filed with Hygiene other the	Com	Elementary/Secondary (0.12) 12 12 17. Father's Name (First, Middle, Last)	College (1-401 3+)	Secre	tary	18 Mother's N	ame (First, Middle,		chool System
/land	Mental Mental Marked of	To Be	Clyde	Hill			Wilda			ooper
Mar	nd 2 shoulth and 27 le mu		Jason R. Hicken -s		19b. Mailii 921 S	ng Address (Stro undew D	eet a <i>nd Numb</i> er or <i>l</i> Prive Alph	aretta, G	r, City or Town, Stat Georgia 30	te, <i>Zip Cod</i> e) 0005
nore,	ages 1 er		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R			sition (Name of matory or other)			20c. Location - City	or Town, State Sville, Marylan
Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 should be Department of Heelth and Menta Importent: If Item 27 Ie marked eny injury of other treumatic engine.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License							A Maryland 20705
68760,	ettending physician and Example of the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Alzheimers Due to (or as a conse Due to (or as a conse Due to (or as a conse	s Disea quence of): quence of):		uying, such as caru	ас от гезрпатогу атг	ө Si,	Approximate Interval Between Onset and Death
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	w requires that been signed b should be deta	क्	Part II. Other significant conditions cor	tributing to death but not re	sulting in the u	nderlying cause	given in Part I.			e to the cause of death? Probably 4 XJnknown
Vital Records,		Completed						24a. Was a autops perform	sy prior med? deat	e autopsy findings available to completion of cause of h? Yes 2 \sumbox No
of	Attending Physicien: death. ctor: After this certific y the funeral director,	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Maner of Death 1 Accident investigation	lospital: 1 Inpatient 2[28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of	1 28c. I		eath (Check only or Home 5 Residence 28d. Describe he		Specify)
Division	or safter Dire	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, offi	Çe	28f. Location (S City or Town		r Rural Route Number,
	Hospital	Medicai	29a. Certifier 1 Certifying Physical Control (Check only one)	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at th vestigation, in n	e time, date and pla ny opinion, death oc	ce, and due to the c curred at the time, d	ause(s) and manne late and place, and	r as stated. due to the cause(s)
	vithir To th	Me	29b. Signature and title of certifier	Lalha	w	D2	ense number 8595		39d. Date signed (M July 11,	
	1		30. Name and address of person who co Tasneem Lakhani,			hts Ave	nue Balti	more, Mar	yland 21	.208
ě.	Sta Regist		31. Date filed (Month, Day, Year) JUL 18 200	Registrar's Sign	ature for	de				

			For State Registrar	State of N	Maryland / Dep	partment of h			giene Reg. No.2 0 0 8	5 24114
			Decedent's Name (First, Middle)	, Last)				2. Date of Dea	ath	3. Time of Death
	Physici: /Medic		Bernard Freder					0	1 10 20	04 38AM
1	Examin	er	4a. Facility Name (If not institution		or)	4b. City, Town, o			4c. County of De	
	Franci		300 Radcliffe 5. Social Security Number		Age (In yrs. last birthda	y) If Under 1 Year	agersto		Washin	gton lirthplace (State or Foreign Country)
	Funeral Director		207-01-4199	1⊠M 2□F	89 Yrs.	Months Days	Hours	Min. 8. Date of Birt (Month, Da Jan. 1	y, Year) .6, 1917 P	Country) ennsylvania
	pu ,		Usual Residence of Decedent 10a. State 10b, County		10c. City, Town or	Legation				10d. Inside City Limits
	shov	ō.		ington	Hager					1 ☑ Yes 2 ☐ No
	28a-f	Director	10e. Street and Number	riigcon	nager	10f. Zip Code			10g. Citizen of What	Country?
	3a or	I Di	300 Radcliffe	Avenue			21740		USA	
99	d within 72 hours after death with the Maryland jiene. I than "natural", or Itema 23a or 28a-f show Its Madical Examitter wat be mailfied at	/ Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decede Armed Force 1 X Yes 2 [If Yes Give	¬No	B. Was Decedent of H If Yes, specify Cub		n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Ar Black, Wi Specify: Wh	
21215-0036	hours ural',	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Date:						
7	n 72 in 72 in at	Completed	15. Decedent (Specify only highes	t grade completed)	(Giv	edent's Usual Occup re kind of work done . DO NOT use retire	oation <i>during most</i> o d)	of working	16b. Kind of Busines	ss/Industry
212	d within plene. r than "	omo	Elementary/Secondary (0-12)	College (1-4c	or 5+)	tal worker			U. S. Gov	ernment
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yla	should be Ind Mental Is marked o	To	Ernest Knott					h Rebecca		
Maryland	12: hai 7 Is trat		19a. Informant's Name/Relational Rodney Price					or Rural Route Number Hagerstown		
	1 and Healf em 2 ther		20a. Method of Disposition			position (Name of ematory or other pla		Date	20c. Location - City	
IOT.			1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		10	rematory or other pla iwn Mem。 P		7/21/06	Hagerstov	m, Maryland
Baltimore,	그 된 원 등 .		21. Signature of Funeral Service					MINNICH F		
Ä	Depa Impo any is		COST	Mala	much	415 E. Wi	1son B	lvd., Hage	rstown, Mo	1. 21740
П			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	sed the death. Do not en line.				4	Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	- a - a 4 / 6	1020/6104	10 Loro	nary	Vascula	_ disease	Chisti and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):		(
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	The law requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	by P	Part II. Other significant condition	715	but not resulting in the	underlying cause giv	en in Part I.	23e. Did to		to the cause of death?
ord	w require been si should I		diabetes mi	2111445				_ 101	res 32 No 3	Probably 4 □Unknown
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al H			hypercholeir	Bielemia				1 ☐ Yes	rmed? death	
Ζ		o Be	25. Was case referred to medical examiner? 1 Yes No	Hospital:	atient 2 ER/Outpati	ent 3 DOA	100	f Death (Check only o		
of	Physer this eral di	H 1	27. Manner of Death	28a. Date of I	njury 28b. Time	of 28c. Injur	4 14015	ing Home SEResid	now injury occurred	оеспу)
ion	Attending In death.	atlo	Natural 5 Pendin investig	9	Day Year) Injury		rk? Yes 2⊟No			
Division		Certification;	3 Suicide 6 Could a determined	ined 288. Place of	Injury - At home, farm, etc. (Specify)	street, factory, office		28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,
	spital or ours afte neral Dir filled in							4		· · ·
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier Certifyin (Check only 2 Medical one)	g Physician: To the be Examiner: On the basis and manner	of examination and/or	ath occurred at the till investigation, in my o	me, date and popinion, death	place, and due to the o occurred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certific	1	-	29c. Licens	se number (29d. Date signed (Mo	nth, Day, Year)
)	F > F 0		> held	XIO			4696	10	07-19.	1006
	- 1		30. Name and address of person	who completed cause of	of death (Item 23a) (Typ	e, Print)		10 Hagers	,	- 1 -
51	1-5+1		W.E. Kutzera	WD 13	124 Pana	sylvana !	wenue	Hagers	DN 2004	21744
	Sta Registi		31. Date filed (Month, Day, Year)		strar's Signature	1.1.				
	ricgisti	CII	301 20	7000 M	we D. fo	perse				

			For State Registrar	State of Ma	aryland		rithent of Fathering				2006	24115
			Registrar 1. Decedent's Name (First, Middle, Last)			Cer	lineale of	Dealli	2. Date of Dea	Reg. No.	2006	3. Time of Death
	Physici	an	ERWIN KADRICHU						July	14°,	2006 2006	9:08 A M
	/Medic		4a. Facility Name (If not institution, give s				4b. City, Town, o	r Location of Deat			ounty of Death	,,,,,
	Examin	eı	Shady Grove Advent	ist Hospi	ltal		Rockv	ille		M	lontgome	ry
	Funeral		Social Security Number	7. Age	e (In yrs. la:	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.				ace (State or Foreign
р	Director		223-33-3346	M 2 F	80	Yrs.	Working Days	1.00.0	May 26	,1926	Indo	nesia
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	calion				10	Od. Inside City Limits
	Manyl feho	5	Md. Montgome	ry	Ger	manto	wn					1 ☐ Yes 2X No
	the 1	rect	10e. Street and Number		l		10f. Zip Code			10g. Cilize	on of Whal Coun	try?
	within 72 hours after death with the Maryland ene. tten "natural", or iteme 23a or 28s-f ehow ta Madical Exarthar must te mutified at	Funeral Director	13027 Middlebrook	Road				20874		Unit	ed Stat	es
	death	ner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S	. 13.	Was Deceden of F f Yes, specify Cub	dispanic Origin? (S	specify Yes or No-	. 14	Race - America Black, White,	
9	or ite	교	1 Never Married 2 Married	1 ☐ Yes 2 🔯 N If Yes, Give	No		i ⊡ Yes 21X No		10 110011, 010.7		pecify: Asi	
8	urai',	d by	3 Widowed 4 Divorced	Year or Dates:								
5	n 72 "nat	lete	15. Decedent's Educ (Specify only highest grade			(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of wo	rking	16D. Kind	f of Business/Ind	ustry
21215-0036	within them.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Mana		-,		Impo	rt/Expo	rt
þ	Hyg othe	e C	17. Father's Name (First, Middle, Last)						me (First, Middle,	Maiden S	umame)	
lar	Alenta Alenta rrked tic e	To B	Choo Chong Sooi					Tan P	ik Djin			
Maryland	and Name		19a. Informant's Name/Relationship (Typ	oe, Print)		19b. Mailir	ng Address (Street	and Number or R	ural Route Numbe	er, City or	Town, State, Zip	Code)
Σ	end alth		Hanny Kadrichu (Da	ughter)								Md. 20878
ore	Charles of		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R	emoval from Slate			sition (Name of natory or other pla		Dete y 17,		ation - City or To	
Ë	Pa tuni jury		4 Donation 5 Other (Specify)		Gat		Heaven Ce	20 am	006		er Sprin	ig, Ma.
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28s-1 ehow any injury or other traumatic event, It a Medical Exactline must be notified at any injury or other traumatic event, It a Medical Exactline must be notified at		21. Signalure of Funeral Service License	Shey			Name and Address O East D					d. 20877
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused to cause on each lin	the death.	Do not ent	er the mode of dy	ng, such as cardia	c or respiratory ar	rest,		Approximate Inferval Between
1	Physician		Immediate Cause (Final disease or condition	arr	y then	n 19						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):						
		-	Sequentially list conditions, if any, leading to immediate		a conseque	ance of).						
	ted nsit	Examiner	trany, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause (Disease or injury									
	Physician: The law requires thet the death certificate be executed this certificete has been signed by the ettending physicien and rail director, page 2 should be detached for use as the burial transit	xar	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):						
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.89	ifficat g phy as the											
Вох	h cert endin r use	N/N	23b. Was decedent pregnant	3c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	v		23	d. Date of delive	,
	o deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown			Other (specify) _				Month	Day Year
P.0	thet the de led by the e detached f	Physician/Med	9 Unknown			tion or the state of the	-4-4-1	on a la Bast t	020 Did to		e analah da la th	a source of death?
	res thei signed t I be det	ρ	Part II. Other significant conditions con	induting to death b	ut not resul	ang in the u	nderrying cause gi	ren in Part I.			No 3 Prob	e cause of death?
Records,	w requir been si should	Completed	119 2 10031271									
3ec	e law has t	d L	Stroke						24a. Was autop	an sy rmed?/	24b. Were autor prior to con death?	sy findings available apletion of cause of
a	icete								1 Yes	2 No		2□ No
Vital	eiciar certii irecto) Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatie	- of	R/Outpatier	it 3□ DOA Ott	100	ath (Check only o		□Other (C	
of O	Phy or this oral d	n: To	27. Manner of Death	28a. Dale of Inju	ry 2	28b. Time o			28d. Describe h)
ion	Attending in death.	atlo	Natural 5 ☐ Pending investigation	(Month, Day	y Year)	Injury		rk? Yes 2∐No				
Division	er des recto by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injuding, ele	ury - At hon	ne, farm, slr	eet, factory, office		28f. Location (S City or Tox		Number or Rura	Route Number,
	itel o irs aft rei Di lled in		, and a second s		1123							
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificete has completely filled in by the funeral director, page 2	Medical	29a. Certifier Check only Check only one)	ner: On the best of and manner sta	f examination	ledge, deat on and/or in	n occurred at the ti vestigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) a date and p	nd manner as st lace, and due to	ated. the cause(s)
	To the To the Complex	Σ	29b. Signature and title of certifier	1	la	MS	29c. Licens				signed (Month, I	
	lo:		, comm	· . sw	V	, 5-9	U	59929		07	1-14-0	6
	6		30. Name and address of person who co					ter Dr.	Rockvill	e. Md	. 20850	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 18 2006

32 Registrar's Signature

06-05085 Hyoun Man Kang

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

,	F	1- For State Certificate (Registrar	of Death		Reg	. No. 200	S 21.11
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last)			2. Date of Death Month I	Day Year	3. Time of Death 1843 hrs
VIEGICAI EXAIIIII		Hyoun Man Kang 4a, Facility Name (if not institution, give street and number)	4b. City, Town, or Loc	cation of Death	July 15, 200	4c. County of Death	
		212 Pender Place	Rockville			Montgomery	
Funeral		5 Social Security Number 6. Sex 7. Age (In yrs. last birthday)		If Under 24Hrs. Hours Min.	8 Date of Birth	(MM/DD/YYYY) 9. Birt Foreign	n
Director		012-30-0702	rs.	riours (viir),	07/29/1	945 Co.	^{intry)} Korea
aux	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation				10d Inside City Limits
ž .			_				1 X Yes 2 No
Maryland 28a-f show 1 at once.	Director	Maryland Montgomery Rockvill 10e. Street and Number	10f. Zip Code		10g	Citizen of What Coun	try?
ith the Maryland 23a or 28a-f she notified at once	اةً	212 Pender Place	20850			Korea	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once		11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispar f Yes, specify Cuban, Mo			14 Race - Americ White, etc	can Indian, Black,
er dea		3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 V No s	pecify:		Specify: Asia	
5-0036 led within 72 hours after dygiene. other than "natural", the Medical Examiner	함	15. Decedent's Education (Specify only highest grade completed) 16a. Deced	ent's Usual Occupation	(Give kind of we		16b. Kind of Business/Ir	ndustry
6 72 ho an "na cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DC		ed)	Swimming P	ool
003 within giene. ner tha	틹	17. Father's Name (First, Middle, Last)	Maintenance		(First, Middle, Ma	Technician	
115-1 e filed al Hyg ed oth		Kyoung Mo Kang		Kyunghe		Zoo	
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than umatic event, the Medica		19a Informant's Name/Relationship (Type, Print) 19b Mail	ing Address (Street ar				Zip Code)
Baltimore, MD 21215-00; pernit Pages I and 2 should be filed with Department of Health and Mental Hygiene Department. If item 27 is marked other timportant: If item 27 is marked other timping or other traumatic event, the Medium of t		0	Pender Plac				
Baltimore, MI permit Pages I and 2 s Department of Health a Important: If item 27	İ	oromaton, or	osition (Name of cemete other place)	ery,	Date	20c. Location - City or	Town, State
Baltimo permit Page Department Important: injury or ot		1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other Specify: 21 Signature of Fungral Service Licensee 1 Removal from State An atomy Registry 22 Signature of Fungral Service Licensee	Nome and Address of	07 /	18/2006	Hanover, M	aryland
Baa Depar Impo		22 Signature of Fundants 4 Multi-	Name and Address of hibadeau Mo 33 Gist Ave	ortuary	Service	P.A.	20910
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not ente failure. List only one cause on each line.	r the mode of dying, suc	ch as cardiac or	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Hanging					Death
May " " " "	- 1	or condition resulting in death) Due to (or as a consequence of):					
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	-				
	Examiner	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last events resulting in death) Last					
cuted		d					
760, toate be executed g physician and the burial - transit	/Medical	UNPENDED AMENDED					
8760, ificate be up physici		IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth 2	Fetal death 3	Ectopic pregnar	псу	23d. Date of delivery Month D	yay Year
Box 68 e death certif the attending	siciar	Pregnant at time of death 5	Other (Specify)				
. Bc the dea y the a	Phy	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause give	en in Part I	23e. Did tob	acco use contribute to	the cause of death?
P.O s that	ē	Gold Back Section Committee Committe	o ag,g			2 No 3 Prob	
rds, require	Completed				24a. Was ar		topsy findings available ompletion of cause of
€COI ne law te has l	dmo				perform	ned? death?	
al Re m: Th ertifica tor, pa	Be Co	25. Was case referred to medical	26 Place of	Death (Check o			· · · · · · · · · · · · · · · · · · ·
Vita hysicia this ce	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	SIK 5 BOX			Residence 6 🗸 Other	: Scene
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ras after death. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury FOUND: Day, Year) FOUND: FOUND: Pay, Year) FOUND:			28d. Describe ho Subject hang	ow injury occurred led self	
SiOl Atten r deat	cati	2 Accident Investigation Jul 15, 2006 1836 hrs			28f. Location (St	reet and Number or Ru	ral Route Number, City
Divi	Certification:	3 V Suicide 6 Could not be determined (Specify) Single Family			or Town, Sta 212 Pender F	^{ate)} Place, Rockville, N	ИD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death oc					
To the within To the comple	edical	one) 2 Medical Examiner: On the basis of examination and/or investi and manner stated.			the time, date a		
	Σ	29b. Signature and title of certifier	29c. License n			29d. Date signed (Mor July 16, 2006	кп, рау, теаг)
ID		30. Name and address of person who completed cause of death (Item 23a)	3.3.W.				
		Melissa Brassell, MD Assistant Medical Examiner 111	Penn Street, Balt	timore, MD	21201		
	ate	31. Date filed (Mo JULY, Yaar 8 2006 32 Registrar's Signature	sell .				
Regist	rar	OOL TO COOL WASHINGTON					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Vear **Physician** 2006 9:00 A 14 July Jerry Kroutil, III /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 10108 Ashwood Drive Kensington
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Montgomery

9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1**⅓**M 2□ F Yrs Director 578-50-4266 June 3, 1940 Washington, DC 66 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "natural", or Iteme 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Kensington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10108 Ashwood Drive 20895 s flied within 72 hours after death validiene.

I Hygiene.

other than "natural", or Iteme 23s USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No If Yes, Give 1963— 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 253 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: If Yes, Give Year or Dates: Spacify by 3 Widowed 4 Divorced 1975 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Aerospace Research Engineer 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If feen 27 is marked oth any njury or other traumatic event page. Be 2 Jerry E. Kroutil, II Gladys Marguerite Chalkley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 10108 Ashwood Drive Kensington, Maryland 20895

20b. Place of Disposition (Name of cemetary, crematory or other place)
Seaside Memorial
Park

July 21,2006 North Carolina Peggy L. Kroutil Wife 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Prancis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 21. Signatur of Funeral Service Licensee ole 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit and resulting in death) Last Due to (or as a consequence of) Box 68760 attending physician Physician/Medical as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year signed by the atte in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy performe 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 No 1 Yes Division of Vital spital or Attending Physician: hours after death.
neral Director: After this certificaty filled in by the funeral director, p Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 29a. Certifier i 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20+1 D 53177 July 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 Medical Center Drive Rockville, Maryland 20850 John M. Wallmark, M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 18

5006

Gostis

32. gistrar's Signature

	- x			Type or Pri State of M							-		Legible.	
			1 - State RegistrerAMEND#19a, 20 1. Decedent's Name (First, Middle, Last	lb+qperFH7/.							2. Date of Dea	Reg. No.	2000	3. Time of Death
	Physici: /Medic Examin	al	JUNG HYUN KIM 4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	of Death	Month JULY	12 4c.	Year 2006 County of Deat	1:47 PM
	Funeral	Ŭ.	SUBURBAN HOSPITAL 5. Social Security Number 6. Se	x 7. A	ge (In yrs. I	ast birthday)		r 1 Year	THESDA	24 Hrs.	8. Date of Birt	h	ONTGOMER 9. Birt	hplace (State or Foreign
L	Director		507-54-1243 Usual Residence of Decedent	M 2□F	74	Yrs.	Months	Days	Hours	Min.	APRIL 20			KOREA
	ne Marylan 8a-f show diffied at	Director	MARYLAND MONTGOMER	Y	10c. City	, Town or Lo	S		SPRIN	G				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with th	Dire	10e. Street and Number				10f. Zij	Code	006				zen of What Co	untry?
980	be tiled within 72 hours after death with the Maryland ital Hyglene. dother than "natural", or items 23a or 28a-f show event, the Mudical Examinational to motified at	by Funerai	3805 GLEN EAGLES DRI 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	VE 12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No	1		dent of Hi			ecify Yes or No- Rican, etc.)	. 1	U.S.A. 14. Race - Ame Black, White Specify: A	
21215-0036	e filed within 72 ho al Hygiene. other than "natur vent, the Medical	Completed	15. Decedent's Edic (Specify only highest grad Elementary/Secondary (0-12) 5+		5+)	life. L		ork done d se retired	turing mosi)	t of work	ing		nd of Business/	
	tould be filed if Mental Hygi narked other	To Be C	17. Father's Name (First, Middle, Last) YOUN DONG KIM								e (First, Middle, IN SONG	Maiden	Sumame)	
Maryland	nd 2 shou aith and M 27 ie mai r traumai		19a. Informant's Name/Relationship (7)	vpe, Print) wife							A Route Numbe			,
Baltimore,	i. Pages 1 and 2 should b timent of Health and Ments reart: If I tem 27 is marked ylury occitant traumatics		20a. Method of Disposition 1									20c. Loc Brei	cation - City or intwood ,	Town, State Maryland
Bal	permit. Depertm Importa any Inju		21. Signature of Funeral Service U ens	I den	Lu									E, INC RYLAND 20904
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cardse (Final disease or condition resulting in death)	ications that cause ne cause on each a. STROKE Due to (or a	line.		er the mod	de of dyin	g, such as	cardiac (or respiratory ar	rest,		Approximate Interval Between Onset and Death
68760,	executed in and ial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b										
P.O. Box 6	death certif e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic p Other (s)					2	3d. Date of deli Month	ivery Day Year
ຜົ	w requires that the been signed by th should be detache	by	Part II. Other significant conditions co	ntributing to death	but not resu	ulting in the ur	nderlying	cause give	en in Part I.	· 				the cause of death?
al Record	The law ete hes b page 2 sl	Completed							_		24a. Was autop perfor 1 🗆 Yes	sy med?	prior to death?	topsy findings available completion of cause of 2 No
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 X No	Hospital:	ient 2 🗆	ER/Outpatien	t 3 D	Othe	201		n <i>Check only o</i> me 5 ☐ Resid		Other (See	N/4.1
on of	Jing After fune	-	27. Manner of Death 1 🖾 Natural 5 🗍 Pending 2 🗍 Accident investigation	28a. Date of Inj (Month, D	ury	28b. Time of Injury		28c. Injun			28d. Describe h			ary)
Division	al or Attends after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, 6	njury - At ho atc. (Specify		eet, factor	y, office			28f. Location (S City or Tow			ral Route Number,
	To the Hospital or within 24 hours after within 24 hours after to the Funaral Direction of the filled in the formula of the filled in the fill	Medical C	29a. Certifier 1 ☑ Certifying Phy (Check only 2 ☐ Medical Exam one)		of examinat									
		W	29b. Signature and title of certifier				29	c. License	number			29d. Date	e signed (Monti	n, Day, Year)
	435	1	30. Name and address of person who c		Ji'lk S	23a) (Tvne	Print)	D	63195			JULY	12, 2006	5
			STEVEN DAVID WILKS, 9	901 MEDICAI	CENTE	R DRIVE		VILLE	, MARY	LAND	20850			
e d	Sta Registi		31. Date filed (Month, Day, Year) TUL 1 4 2	32. Pegis	trar's Signa	ture A	whi	9						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland / [1ental Hygi	_	24119
~	100 E 2	t.	Decedent's Name (First, Middle, Last)			204171	2. Date of Death	1	3. Time of Death
	Physici /Medi		Robert Gordon Leat	herman. Sr.			July	16 2006	5:05 A ^M
	Examir		4a. Fecility Name (If not institution, give stre	et and number)	4b. City, Town,	or Location of Death		4c. County of Death	3.03 11
1		-3-2-1 -3-3-1 -3-3-1	17604 Cedar Lawn I	Drive		Hagerstown	1	Washing	ton County
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bir	Months Dave		8. Date of Birth (Month, Day,	Year) 9. Birthp	place (State or Foreign
	Director		Usual Residence of Decedent	77	Yrs.		August	2 1928 Mai	ryland
	/iand		10a. State 10b. County	10c. City, Tow	n or Location			1	Od. Inside City Limits
	Man Freh	to	Maryland Washingt	on Ha	agerstown				1 □ Yes 3x No
	or 284	re	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cour	ntry?
	th wi	ia D	17604 Cedar Lawn I	Drive		21740		U.S.A.	
	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than *natural', or itema 23a or 28a-f ehow event, the Medical Examiner must be multified at	Funeral Director		Was Decedent Ever in U.S. Armed Forces?	13. Was Oecedent of If Yes, specify Cul	Hispanic Origin? (Spo ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	or II	by Fi	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No 6-195	1 Type 2 No		, ,	Specify: Whi	
21215-0036	tural	ed b	15. Decedent's Educat	Year or Dates: 3-195.	9	potion			
5	in 72	Completed	(Specify only highest grade c	ompleted)	Give kind of work done life. DO NOT use retire	during most of work	ing	6b. Kind of Business/In	dustry
212	d within jene. r than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Mechan	•		Self Emplo	boye
	e filed of Hygie other vent,	a)	17. Father's Name (First, Middle, Last)			18. Mother's Name	First, Middle, M		yeu
<u>la</u> r	uld be Mental irked c	To B	John Clyde Leather	man		Vallie	. Virgini	a Whittingt	con
Maryland	s 1 and 2 should f Health and Men Item 27 le marke other traumatic		19a. Informant's Name/Relationship (Type,	Print) 19b	. Mailing Address (Stree	t and Number or Rura	al Route Number,	City or Town, State, Zip	Code)
	and and m 27		Patricia A. Leathe		7604 Cedar 1	Lawn Drive	Hagerst	own Marylar	nd 21740
ore	ges 1 a it of Hez iff Item or othe		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Rem	20b. Place of	Disposition (Name of y, crematory or other pla			0c. Location - City or To	
Ē	Pages ment of lant; if its	1	4 □ Donation 5 □ Other (Specify)	Cedar	Lawn Mem Pa		20 06	Hagerstown	Maryland
Baltimore,	permit. Pages Department of Important; If I eny injury or once.		21. Signature of Funeral Service Licensee	7 '	22. Name and Addr	100		Fiery Fune	
	20 = e d		Daylor H.	My				rstown Mary	land 21742
п			23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one of	ions that caused the death. Do reause on each line.	not enter the mode of dy	ing, such as cardiac c	or respiratory arres	st,	Approximate Interval Between Onset and Death
A.	Physician		Immediate Cause (Final disease or condition resulting in death)	Cercun	ore of	mas	tele	6) UCEN
	/Medical Examiner		resulting in dealth)	Due to (or as a consequence	of):	.			
		*	Sequentially list conditions, b	Due to (or as a consequence of	96 ¹¹				
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (0. 20 2 00)1004201100 (,				
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68	ifficat g phy as th								
Вох	death certifica e attending ph ed for use as ti	Physician/Med	23b. was decedent pregnant	If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	2054			23d. Date of delive	ry
	deat ne att ed for	Sicia	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4 Pregnant at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	:y		Month	Day Year
P.O.	that the de led by the a detached f	بار چر	9 Unknown						
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ord	equir sen s	ted					1 Tes	2 2√No 3 □ Prob	ably 4 □Unknown
Records,	ne law require has been sig ge 2 should b	Completed					24a. Was an autopsy	prior to con	osy findings available inpletion of cause of
Œ .	: The	Cou					performe 1 ☐ Yes 24	ed? death? 1 ☐ Yes	
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	sitali	10	26. Place of Death			
of	Phys this al dir	10	1 ☐ Yes 2 No Host	1 Inpatient 2 EH/Ou	tpatient 3 DOA	ner: 4 Nursing Hor		ce 6 □Other (Specify)
L C	ding After funer	e l	1. □Natural 5 □ Pending		njury Wo	rk?	28d. Describe how	rinjury occurred	
Si	Attending in death. ector: After by the fune	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be ☐	28e. Place of Injury - At home, far]Yes 2 □No	291 Location (Stre	et and Number or Rura	I Davida Al
Division of Vital	lor A after Direc	Certification;	4 ☐ Homicide determined	building, etc. (Specify)	m, street, factory, office	-	City or Town,	State)	Houle Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: Atter this certificate he completely filled in by the funeral director, page		29a. Certifier Jacob Certifying Physici	an: To the best of my knowledge	, death occurred at the ti	me, date and place, a	and due to the cau	(se(s) and manner as st	ated
	e Ho 124 h Fui letely	edical	(Check only 2 Medical Examiner one)	On the basis of examination and and manner stated.	Vor investigation, in my	opinion, death occurre	ed at the time, dat	e and place, and due to	the cause(s)
	To the lawithin 2. To the complet	Me	29b. Signature and title of certifier		29c. Licens	se number	290	d. Date signed (Month, L	Day, Year)
			fresioner !	t Vi	mod D	23825		7/16/	66
			30. Name and address of person who comp	leted cause of death (Item 23a) (Type, Print)		A 2	// -/	^ ^
5H	5+1		1- ridure It	KASSIAN	M 1111	D Me du	رو) کم	men	(2)
	Sta	_	31. Date filed (Month, Day, Year) JUL 18 2006	32. Pegistrar's Signature	South		1	,	,
	Registr	ar	JUL 10 2000	Janen D.	sperce			Ecerstrum	1 mil

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Jime of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JULY 18 2006 Carol Ann Lynch 1:15 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 270F Yrs. Director 62 577-56-9058 June 6,1944 Washington, DC Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 🔯 No MD Calvert Huntingtown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1010 Stephen Reid Drive 20639 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Dept. of Justice secretary permit. Pages 1 and 2 should be file Department of Health and Mental Hy importent: If Item 27 Is marked othe eny injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Mickey Elinor Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1913 Wooded Trace, Owings, MD 20736 Roy H. Brown, brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 07-21-2006 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. Signature of Funeral Service License 23a. Part 1. Enter the islease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 1 filtyre. List only one cause on each line. 8325 Mt. Harmony Lane, Owings, MD Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Matastanc Cans **Physician** C94(C6 Months /Medical Due to (or as a consequence of): Examiner Years Empysema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) respisato, failusz 4ours the ettending physicien and hed for use as the burial-transit The law requires that the death certificate be executed MYZUXIC hours SEPSIS Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 3 □€ctopic pregnancy 2 | Fetel death in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ GAILEPSY. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 29b. Signature and title of Dertifier 29c. License number 29d. Date signed (Month, Day, Year) Slew 7/18/06 10061719 30. Name and a Tress of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)
JUL 1 9 2006

lO)

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division of Vital

CAROL

DR.BHAVSAR 24035 THREE NOTCH RD HOLLYWOOD MD 20636

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Robert Andrew Lazun 6:03^{a м} July 15, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Takoma Park
If Under 1 Year | If Under 24 Hrs. Washington Adventist Hospital Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**X** M 2 □ F Yrs. 69 185-26-7688 Director March 29, 1937 Pennsylvania Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Director Maryland Montgomery Takoma Park 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7309 Cedar Avenue 20912 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □X/es 2 □ No If Yes, Give Year or Dates: 1962-65 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 3 Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 ☐xNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Elementary/Secondary (0-12) Coflege (1-4or 5+) Clinical Social Worker/Educator Self Employed and Mental Hygie Is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be Michael Lazun Mary J. Spevak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If Item 27 Is i ury or other traus Susan Kessler/ Wife 7309 Cedar Avenue, Takoma Park, MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State July 18. Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 2006 21. Signature of Funeral Service Licensee Francisd Address Collins Funeral Home Inc. Millian Z 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that shock, or heart faifure. List only one cause a Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fmmediate Cause (Final Physician disease or condition resulting in death) /Medical ENIA Z PNEUMONIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner ed by the attending physician and detached for use as the burial-transit resulting in death) Last Box 68760. certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by to Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 cete hes been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 nknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy Vital 1 ☐ Yes 2 100 1 Tes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Linpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA Division of this 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural Accident 5 Pendina death. 1 ☐ Yes 2 ☐ No investigation after death Director: A 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel of within 24 hours at To the Funeral D completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20+1 ompleted cause of death (Item 23a) (Type, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 18 2006 Registrar

			1 - For State Registrar	State of Maryland	-	rtment of H		F	leg. No.	2006	24122
	Physici /Medic		1. Decedent's Name (First, Middle, Last Maria	J. Leyto	n			2. Date of Dea Month July		200 ⁶	3. Time of Death 5:45p M
	Examir		4a. Facility Name (If not institution, give 5605 59th Aven			River			P	County of Death	George's
	Funeral Director		0.3 0	7. Age (In yrs. le	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 3 / 0 3 / 1	903		place (State or Foreign intry) aragua
	Maryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County MD Prince		Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	a with the 3a or 28a-	Funeral Director	10e. Street and Number 5605 59th Aven	ue		10f. Zip Code 20737	7	1	l 0g. Citiz	en of What Cou	
0	affer death or Items 2	y Funera	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Vas Decedent of Hi Yes, specify Cuba		pecify Yes or No- o Rican, etc.)		4. Race - Amer Black, White Specify: T	, etc.
0500-61	in 72 hours n'natural', legical Ex	Completed by	3 Widowed 4 □ Divorced 15. Decedent's Edi (Specify only highest grad	Year or Dates: ucation le completed)			icaraqu			d of Business/li	Vhite
717 D	filed with Hygiene. ther ther		Elementary/Secondary (0-12) 6 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		nemaker		ne (First, Middle, i		n Home	
ryland	hould be d Mental marked c matic eve	To Be	Pablo Alonso 19a. Informant's Name/Relationship (T)	una Print)	10h Mailin	g Address (Street a	Jul	iana Cu	adra	a	in Code)
iore, ma	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-6 show eny injury or gither treumatic event, Ine Medical Examinar must be notified at once.		David Leyton/Se 20a. Method of Disposition 1	On 20b. Pla	5605 ace of Dispos metery, crem	59th Av	venue Ri	iverdal	e , Ma 20c. Loc	arylan ation - City or T	d 20737 Town, State
Dallimor	Department Important eny injury once.		4 □ Donation 5 □ Other (Specify 21. Signature // Pun rad Service //cons	100-10	PF	d Nat.Mo Paragraph 241 colu	RINALD	FUNER	AL S		
Í	Physician hybridian and hybridian and hybridian street burial-transit street burial-tran	edical Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying	ne cause on each line. a. Electrolyte Due to (or as a conseque b. Skin infect Cus to (or as a conseque c. Muocardial Due to (or as a conseque d.	e imba ence of): ion infai	alance					Approximate Interval Between Onset and Death
O. DOX 00	to the nospital of attending Priysician: The law requires that the death certains within 24 hours after death. To the Funarel Director. After this certificate has been signed by the attending pf completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the complete of the complete of the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)			23	3d. Date of deliv Month	rery Day Year
cords, r	w requires thet been signed b should be deta	þ	Part II. Other significant conditions co		iting in the un	derlying cause give	on in Part I.		oaccous es 2√∑		the cause of death? bably 4 Unknown
יים ויי	ding rnysician: The law re h. After this certificete hes bei funeral director, page 2 sho	Completed						24a. Was a autops perform	ned?	24b. Were autoprior to codeath?	opsy findings available ompletion of cause of
	nysician iis certif director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	3□ DOA Othe	· ·	th <i>Check only on</i> ome 5 ∑ Reside	-10	☐Other (Speci	(v)
	ath. rr: After the funeral	ertification:	27. Manner of Death 1 Manural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho			
באר ביינול ב	ital of Attending after death	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (St. City or Town	reet and n, State)	Number or Run	al Route Number,
	vithin 24 hours after or within 24 hours after To the Funerel Dir completely filled in	Medical	(Check only 2 ☐ Medical Exami one)	sician: To the best of my know ner: On the basis of examinational manner stated.	rledge, death on and/or inv	estigation, in my op	inion, death occur	rred at the time, da	ate and p	place, and due t	o the cause(s)
,	with Con	2	29b. Signature and title of certifier	Janule	7	29c. License	58213	2		signed <i>(Month,</i> July 1	Day, Year) 7,2006
			30. Name and address of person who carhad Jamal			_{Print)} er Parkv	vay #A (Greenbe	lt.N	Md 207	70
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signatu	150	ules .					

			1 - For State Registrate NEND#1perMD7/26		aryland / Dep	artmen			ınd M	lental Hy	giene Reg. No	106	24/23
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) MARC AARON AARON 4a. Facility Name (If not institution, give s	LIPSI	A. LIPSI		Town, or	Location o	f Death	2. Date of De Month JULY	Day 17	Year 2006 ity of Death	3. Time of Death 3:45 A M
	Funeral Director		1000 WIND RUSH LANE 5. Social Security Number 219 72 1787 6. Sex	7. Ag	e (In yrs. last birthday 50 Yrs.			NG If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da		Co	nplace (State or Foreign untry) hington, D. C
	σ	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	rv	10c. City, Town or L					July 1	0 1930	wasi	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28a	Funeral Directo	10e. Street and Number 1000 Wind Rush Lan		T During Op.	10f. Zip	Code 2086	0			10g. Citizen o		untry?
-0036	n 72 hours after death with the Maryland "natural; or Iteme 23a or 28a-f ehow ealtal Expenies must be notified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		No 16a Dece	1 🗆 Yes	2€No	Specify:		ecify Yes or No Rican, etc.)		lack, White	Lte
Maryland 21215-0036	be filed within 72 tal Hygiene. d other than "natevent, it a Mis Jic.	Completed by	(Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5	(Give	Prod	rk done d se retired, ucer					ladio	
arylan		To Be	Herbert Lipsitz 19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mail	ing Address	(Street a	Paul	ine	Delorm			îp Code)
Baltimore, Ma	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 is marked any Injury of other traumatic e once.		Jeri Ann Shearer-1 20a. Method of Disposition 1 Burial 2 ②Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funer Service License	emoval from State	20b. Place of Disp cemetery, cre Ft Linco	osition (Nar matory or o In Cr 2. Name an	ne of ther place emat d Addres	ory s of Facility	7/20 Hine	/2006 s Rina	20c. Location Brentw ldi Fun	ood, eral	Maryland
8760,	Physician and ph	dical Examiner	23a Part1. Enter the disease, or compile shock, of heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Law Leading to annuadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Non Sma Due to (or as	d the death. Do not erne. 11 Cell Lu a consequence of): a consequence of): a consequence of):				cardiac c	r respiratory a	rrest,		Approximate Interval Between Onset and Death 3 Years
P.O. Box 6	The law requires that the death certificate atle has been signed by the atlanding physpage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pr □ Other (sp						ate of deliving	very Day Year
Records, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death b	out not resulting in the i	underlying c	ause give	n in Part I.					the cause of death?
Vital Rec	i cie n: The law certificate has b rector, page 2 sl	e Completed	25. Was case referred to medical					26 Place	of Death		psy ormed? 252 No	prior to condeath?	opsy findings available ompletion of cause of
Division of V	Attending Physic death. •ctor: After this by the funeral did	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Note Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Inju (Month, Da	ent 2 ER/Outpatie ry Year) 28b. Time of Injury ury - At home, farm, si c. (Specify)	of 2	8c. Injury Work 1 🗆 Y	4 Nur	lo	28d. Describe		ırred	rfy) ral Route Number,
۵	Hospita 4 hours Funeral	Medical Cer	29a. Certifier 1 Certifying Phys (Check outy one) 1 Medical Examin	icien: To the best ler: On the basis of and manner st	of my knowledge, dea f examination and/or in	th occurred ovestigation	at the tim	e, date and inion, deat	place, a	and due to the	cause(s) and r	nanner as o, and due	stated. to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier ### ### ############################		erly ms	. 1	D32	number 2407			29d. Date sign	17,	
			30. Name and address of person who con Joseph M. Hagger	ty, M.D.	9707 Med	ical (Cente	er Dri	lve ;	#300 Ro	ckville	e, MD	20850
	Sta Regist		31. Date filed (Month, Day, Year) JUL 18 200		ar's Signature	ed l							

06-05393 Please Type or Print in Black Indelible Ink Wayne . bindsay State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Amend item#18, perINf, C858, 8/7 Gertificate of Death Reg. No 1. Oecedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 24, 2006 Wayne H. Lindsay Medical Examiner 1540 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Oeath 4c. County of Oeath Curran Road 🕈 Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/OO/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) Funeral Months Oays Foreign Country) Pa. MD Hours Director 190-30-5632 09/09/38 67 1 X M 2 Usual Residence of Oecedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County Fayette Uniontown 1 X Yes 2 No or 28a-f show Pa. death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 15401 89 Clarendon Ave 23a Funeral 11. Marital Status 12. Was Oecedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 XMarried Yes 2X No after If Yes, Give Year Specify: White 3 Widowed Divorced Yes 2 X No specify: than "natural", à 16a. Oecedent's Usual Occupation (Give kind of work done Pages I and 2 should be filed within 72 hours nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natur or other traumatic event, the Medical Exami 15. Oecedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. OO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Painting Contractor Private 12th Wother's Name (First, Middle, Maiden Surname)

Beana V. Bittinger 17. Father's Name (First, Middle, Last) Be Harold S. Lindsay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15401 89 Clarendon Ave Uniontown, Pa. Wife Jean Lindsay 20a. Method of Oisposition 20b. Place of Oisposition (Name of cemetery, 20c. Location - City or Town, State Important: If it Burial 2 XCremation 3 crematory or other place) Removal from State 07/26/06 |Beltsville,Md Chesapeake Department Oonation 5 Other Specify. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility naldi Funeral Service, P.A. Columbia Boulevard Silver Spring, Md 9241 23a. Part I. Enter the disease, or complications that caused the death. Oo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Between Onset and /Medical Arteriosclerotic cardiovascular disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Oue to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause Oue to (or as a consequence of): (Oisease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Division of Vital Records, P.O. Box 68760, rate of Attending Physician: The law requires that the death certificate be executed Physician/Medical item#23a,PII,2/,perME,9858,8/3/06 TT item#4a,perME,9,18,perFH,C858,8/2/06 TI the attending physician a ed for use as the burial -XXUNPENOEO **AMENOEO** IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Oay Year past 12 months? Pregnant at time of death Δ Other (Specify) 1 Yes 2 No 9 Unknown g Linknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Oid tobacco use contribute to the cause of death? þ **Emphysema** Yes 2 No 3 Probably 4 ✔ Unknown Completed this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director; 25. Was case referred to medica 26.Place of Oeath (Check only one) Be examiner? Hospital: 1 Other, Inpatient ER/Outpatient 3 OOA Nursing Home 5 Residence 6 V Other: Scene 1 V Yes No 27. Manner of Oeath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Oescribe how injury occurred Certification: 1 X Natural Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide determined Homicide

9

29a. Certifier 1

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cale

2006

Medical

State

Registrar

and manner stated

Assistant Medical Examiner

se of death (Item 23a)

Registrar's Signature

SOUTH S

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.

2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

July 25, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** Troy Jr 3:17 PM Miller 7 2006 July Janie /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Battimore Examiner Ba er 1 Year If Under 24 Hrs. 6. Sex 7. Agel (In yrs. last birthday) Johns 8 Date of Birth
Month Pay, Year) If Under Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours X□M 2□F 6 218-57-0056 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 28e-f ehow the Medical Exercites must be notified at Washington Hagerstown MD TX Yes 2 □ No Director 10f. Zip Code 21740 10g. Citizen of What Country? U.S.A. 10e. Street and Number 5 233 S. Locust St. Iteme 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene Important: if Item 27 ie marked other than "natural", or Item any injury or other traumatic event, the Madigal Exempted PRESE Black, White, etc. White 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. Completed by If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) child 0 18. Mother's Name (First, Middle, Maiden Sumame)
Toni Marie Bean 17. Father's Name (First, Middle, Last) Be Daniel Troy Miller Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 233 S. Locust St. Hagerstown, MD 21740 Daniel Miller Sr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of JuP♥ 21 20a. Method of Disposition Rose Hill Cemetery 1 Surial 2 Cremation 3 Removal from State 2006 Hagerstown, MD 5 ☐ Other (Specify) Donald Edwin Thompson Funeral Home, Inc P.O.BOX 310 Clear Spring, MD 21722 Approximate Interval Between Onset and Death Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head railure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** 2 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, lary leading 1, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) P.O. I cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2☒ No Avenia thistory of prentinty
25. Was case referred to medical 1 Yes 2 № No or Attending Physician: funeral director, Be 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours efter To the Funerel Dire 4 | Homicide 29a Certifler 1 Certifying Physician: To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 July 17, 2006 30. Name and ad in the of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

6+1-0

DHMH 17 Rev 1/2001

North Wolfe

2 1 2006

31. Date filed (Month, Day, Year)

Street

32. Registrar's Signature

Honory Maryland

			For State Registrar	State	of Man		artment of lartificate of		Mental Hygie	ene 4. No. 2 N N 6	24126
			Decedent's Name (First, Middle	, Last)					2. Date of Death	too of all	3. Time of Death
	Physici /Medic		MILTON DAVID	MOATS			· · · · · · · · · · · · · · · · · · ·		July	17 2006	11:28 PM
	Examin	er	4a. Facility Name (If not institution	, give street and	number)		4b. City, Town,	or Location of Dea	ith I	4c. County of Deat	h
			WASHINGTON COU					AGERSTOW		WASHIN	
	Funeral Director		5. Social Security Number 220–16–1545	6. Sex 1 ∑ M 2 □ F		n yrs. last birthday Yrs.	Months Days		(Month, Day,	Year) 9. Birtl	nplace (State or Foreign untry) RYLAND
	D .		Usual Residence of Decedent								10111100111
	how	_	10a. State 10b. County		10	0c. City, Town or L	ocation.				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	Ba-t-	cto	MARYLAND WASH	INGTON				BOONSBOI			
	ith th	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	untry?
	23e	rai	7727 SHARPSBURG	PIKE				21713		U.S	
	e La Cara	Funeral	11, Marital Status	Armed	ecedent Eve Forces?	er in U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? (pan, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - Ame Black, White	
36	or it	by Fu	1 Never Married 2 Marr	If Yes,			1 ☐ Yes 2 ☑ No	Specify:		Specify:	
ë	urei'	d b	3 XWidowed 4 ☐ Divorced		r Dates:	16a Daa	edent's Usual Occu	enetion	1.1	6b. Kind of Business/	WHITE
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f ehow he Medical Exertir er mast be motified at	Completed	(Specify only highes	t grade complete		(Giv	e kind of work done DO NOT use retire	during most of w	orking	ob. King of business/	industry
12	with:	E C	Elementary/Secondary (0-12)	College	e (1-4or 5+)		TRUCK	DRIVER	-	FEED MI	T.I.
	Hygir Other ent, II	BeC	17. Father's Name (First, Middle,	Last)					ame (First, Middle, Mi		
Maryland	uges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mentel Hygiene. It if tem 27 is marked other than "naturel", or items 23a or 28a-1 show or other traumatic event, It a Madical Examinating Inviting a	To B	HENRY DAVID MOA	ATS				MAMIE I	E. MOATS		
ary	2 should to and Ment to marked		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mai	ling Address (Stree	t and Number or F	Rural Route Number,	City or Town, State, 2	(ip Code)
Σ	1 and 2 Health a tem 27 is		MAXINE D. MOATS	S/DAUGHT	ER	4 DE	XTER DRI	VE, MART	INSBURG, W	EST VIRGIN	NIA 25405
ore.	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 DRamoval fro		20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ace)	Date 2	Dc. Location - City or	Town, State
Ĕ	Pag nent ant: h		4 Donation 5 Other (S		JIII State	MANOR CH	TURCH CEM	ETERY 7/	21/2006 P	CONSBORO.	MARYLAND
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		21. Sign sture of Furieral Service		enal M	. Dean	22. Name and Addr BAST FUNE	ess of Facility	7606 Old	National	
<u> </u>	20 E 9 9		Taul //4	1000						o, Marylar	
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications the only one cause of	at caused the in each line.	e death. Do not er	nter the mode of dy	ing, such as cardi	ac or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_a. Co	neerte	u Hea	A Face	en			20 mul
	/Medical Examiner		resulting in death)	Due	or as a c	onsequence of):	nt Facel				
	*	_	Sequentially list conditions,	b. Cri	wal	onsequence of):	lage Harl	u Sten	or.		
	ted nsit	ntne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(10 (0, 23 2 0	onsuquunoo ory.	V				
,	execunand n and lal-tra	Examiner	that initiated events resulting in death) Last	c. Due	to (or as a c	consequence of):					
8760,	icate be executed physicien and s the burial-transit	dicat		し d							
9	tifical og ph as th	Medi	IE EENAN E								
Вох	th cer endir r use	an/	IF FEMALE: 23b. Was decedent pregnant		outcome of		□Ectopic pregnan	CV		23d. Date of deli	The state of the s
о. П	requires that the death certifineen signed by the attending thould be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		egnant at tim known	ne of death 5	Other (specify)			MONUT	Day Year
P.O.	hat th rd by detacl	F.	Part II. Other significant condition	ons contributing to	o death but r	not resulting in the	underlying cause g	iven in Part I	23e. Did toba	acco use contribute to	the cause of death?
ds,	es no ed	d by	chanie manual) lailus		hannadia	Our i		1 ☐ Yes	: 2 Ø No 3 □ Pr	obably 4 Unknown
Ö	v requir been s should	ete	_anoma juvas	June		NO VVIDE	Jan		24a. Was an	24h Word av	tensy findings available
Rec	e lav	Completed							autopsy	prior to d	topsy findings available completion of cause of
a		င္ပ	25. Was case referred to medical					00 0110			2□ No
⋚		o B	examiner?	Hoonital	Inpatient	2 ER/Outpatie	ent 3 DOA	thor	eath (Check only one	nce 6 Other (Spec	nés)
ō	Physer this eral di		27. Manner of Death	28a. 0	ate of Injury	28b. Time	of 28c. Inju	ury at	28d. Describe how		sily)
ion	Attending r death. ector: After by the fune	aţio	1 Natural 5 Pendin	g	fonth, Day Y	'ear) Injury		ork?]Yes 2∏No			
Division of Vital Records,	ar desirecto	Certification:	3 ☐ Suicide 6 ☐ Could determ	ined 289. Pl	ace of Injury uilding, etc. (treet, factory, office)	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
Ö	ital or rs efte ai Dir	Cer			, , , , , , , , , , , , , , , , , , ,	-,,,					
	To the Hospital or Attending Phwithin 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edicai	(Check only 2 Medical one)	Examiner: On th	the best of re e basis of ex nanner stated	camination and/or	ith occurred at the nvestigation, in my	time date and pla- opinion, death oc	sa, and dua to the eac curred at the time, dat	ite(t) and manner at te and place, and due	stated. to the cause(s)
	within To the To the Comple	Me	29b. Signature and title of certifie				29c. Licer	nse number	29	d. Date signed (Monti	h, Day, Year)
	->-0) Ast	1			D	3251	8	July 18	2006
•		1	30. Name and address of person	who completed c	ause of deat	th (Item 23a) (Type	o, Print)	.)	1	00 - 1	1
St	1-8			enet	21	Wyan	d Driv	e Kee	aysuille	Maryk	and
OT.	Sta		31. Date filed (Month, Day, Year)	3 2006	2. Registrar's	s Signature	and a			d. Date signed (Month July 18 Maryk	
	Regist	ell	JUL 10	4000 4	(Mich) see	1 11. 10	Contract of the second				

			For State Registrar		•	partment o			Reg. No.	5 24127
	Physicia		1. Decedent's Name (First, Middle, Las Anita E. Miller	st)				2. Date of Dead Month	1 ²⁵ , 2006	3. Time of Death 7:23 P M
	/Medic Examin		4a. Facility Name (If not institution, give		, # 706		n, or Location o		4c. County of Dea	
Aft.	Funeral Director		377 30 3300	ex □M 2∏ F	(In yrs. last birthd 75 Yrs	Months Da		8. Date of Bird Min. (Month, Da May 29	9. Bi y, Year) 1931 Wa	othplace (State or Foreign country)
	Maryland f show		Usual Residence of Decedent 10a. State 10b. County Maryland Montgom	ery	10c. City, Town o					10d. Inside City Limits t√□ Yes 2 □ No
	or 28a-	Oirect	10e. Street and Number	11 71 1	# 706	10f. Zip Coo			10g. Citizen of What C	Country?
36	in 72 hours after death with the Maryland "natural," or Itams 23a or 28a-f show ladical Examinat must be nutified at	by Funeral Director	3310 N. Leisure W 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1	ver in U.S.		ol Hispanic Orig Cuban, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)		
21215-0036	within 72 hou ene. then "nature ne Maples E	Completed	(Specify only highest gra	ducation ide completed) College (1-4or 5-	(G lif	ecedent's Usual Ocitive kind of work do e. DO NOT use re memaker	ccupation one during most etired)	of working	16b. Kind of Busines Own Ho	
land 2	be filed ntal Hygi od other event, I	To Be Co	12 Years 17. Father's Name (First, Middle, Last) Julius Frager		110	memarer		r's Name (First, Middle, arl Ehrlich		
, Maryland	s 1 and 2 should I Health and Men Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Sheldon Miller (H	636.5	19b. M Dan 117	ailing Address <i>(Str</i> zansky-G 0 Rockvi	oldberg lle Pik	r or Rural Route Numbe Memorial C e, Rockvill	er, City or Town, State, Chapels, In .e, Marylan	Zip Code) C. d. 20852
Baltimore,	00-		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3人 4 ☐ Donation 5 ☐ Other (Specified)	y)	20b. Place of Dicemetery, King Da		Gdns	7/17/2006		rch, Virgini
Ball	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licer	Stottle	nyes	1170 Roc	kville	erg Memori Pike, Rock	ville, Mar	yland 20852
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each lin a. Due to (or as a	Consequence of):	toio /	freh	vitis u Nifea		Approximate Interval Between Onset and Death 3 O Yellus
*	i i	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of):	usin	J	u vic fea	· ·	10 years
68760,	icate be physicil s the bu	edicai	•	d						
.O. Box (The law requires that the death certificate be executed tte has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal death	3 □Ectopic pregn: 5 □ Other (specify			23d. Date of d Month	elivery Day Year
۵.	quires that t n signed by uld be deta	ρ	Part II. Other significant conditions of	contributing to death bu	t not resulting in th	e underlying cause	e given in Part I.		obacco use contribute Yes 2 No 3 F	to the cause of death? Probably 4 @Wnknown
Records,		Completed						24a. Was autop perfo	prior to death?	
Vital	Physician: This certifical	Be	25. Was case referred to medical examiner?	Hospital:			0.1	ol Death (Check only of		
of	fing After funer	ation: To	1 Yes 2 No 27. Manner ol Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	v 28b. Tim	e ol 28c.	Injury at Work?		dence 6 □Other (Sp how injury occurred	ecify)
Division	- 0 - C	Certification:	3 Suicide 6 Could not be determined		ry - At home, larm . (Specify)	, street, factory, off	fice	28l. Location (: City or Tox	Street and Number or F Nn, State)	Rural Route Number,
	To the Hospitel of within 24 hours af To the Funeral D completely filled in	<u>a</u>						d place, and due to the th occurred at the time,		
	To the comp	W	29b. Signature and title of a riffier 29b. Signature and title of a riffier 30. Name and address of person who was a result of the company	nus		29c. Lie	cense number		29d. Date signed (Mor	7006
	-		30. Name and address of person who	completed cause of de	aath (Item 23a) (Ty 3305 No	Print) In Lee su	yhor	of Soulera	d. Silver +	Kay Uteryland
	Sta Regist	ate rar	31. Date liled (Month, Day, Year) JUL 18 2	32 Registra	r's Signature	parti				

		•	For State Registrer	State of Maryland /	Department of He		tal Hygiene Reg. No.	
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last)	A MUL	-CARE		Date of Death Month Day	5,2006 11:27/4M
	Examin	er	4a. Facility Name (If not institution, give st Hebrew Home of Grea		4b. City, Town, or RockV			. County of Death Nontgomery
	Funeral Director		5. Social Security Number 6. Sex	M 2∑F 7. Age (In yrs. last b			Date of Birth Month Day, 1921	
	D	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wπ or Location			10d. Inside City Limits
	e Maryl ta-fsho	ctor	Virginia Fairfax	McLea	-			1 Tes 2 No
	with th	I Dire	10e. Street and Number 1515 Great Falls S	Street, #107	10f. Zip Code 22101			tizen of What Country? Jnited States
36	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or itams 23a or 28a-f show event, the Medical Eracin at must be routhed at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 2 ◯ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cubar 1 Yes 2 No	spanic Origin? (Specify n, Mexican, Puerto Rica Specify:	Yes or No- n, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
2-0	"natura	eted	15. Decedent's Educ (Specify only highest grade		a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired,	ation furing most of working	16b. Ki	(ind of Business/Industry
21215-0036	e filed within al Hygiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 1 Re	ealtor			Real Estate
힏	uld be filed Mental Hygirked other tic event, I	To Be C	17. Father's Name (First, Middle, Last) Walter	Estl		18. Mother's Name (Fill		Miller
Maryland	ind 2 should be alth and Mental 27 is marked or traumatic every		19a. Informant's Name/Relationship (Typ. Jacqueline M. Frank	k -daughter 64	9b. Mailing Address <i>(Street a</i> 429 Kenhowe D	rive Bethes	oute Number, City of Sda, Mary	or Town, State, Zip Code) 7 Land 20817
Jore,	it of Hei		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	amoval from State 20b. Place cemet	of Disposition (Name of tery, crematory or other place	Date patory 7/16		ocation - City or Town, State exandria, Virginia
Baltimore,	permit. Pages 1 and 2 should by Oberariment of Health and Menta Important: If item 27 is marked any injury perpether traumatic and ones.		'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		22 Name and Address	Borgwardt I	Funeral H	
Ī			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do	o not enter the mode of dying	g, such as cardiac or re	spiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	BREAS Due, to (or as a consequence	TCHNO	PERTE		
	Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence		PERIC	IVTIU	
	ate be executed oblysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		e of):			
8760,	ate be e hysician the buria	Ical	L.	I				
D. Box 6	e death certific he attending posed for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown				23d. Date of delivery Month Day Year
ds, P.O	uires that the signed by t d be detach	þ	Part II. Other significent conditions con	ntributing to death but not resulting	g in the underlying cause give	en in Part I.	23e. Did tobacco	use contribute to the cause of death?
Records,	The law require te has been si age 2 should t	Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vital	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner?	Hospital:	Other SERVA Other	26. Place of Death (C		
of	ling Ph After th funeral	tlon: To	1 Yes 2 No 27. Marcer of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 EHV	o. Time of 28c, Injury World	4 Wildursing Home	. Describe how inju	6 □Other (Specify) ury occurred
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely lilled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f.	Location (Street ar City or Town, State	nd Number or Rural Route Number, te)
	Hospita 24 hours Funeral etely lilled	edical C	29a. Certifier 1 Certifying Physic (Check only one)	sicien: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death occurred at the tin and/or investigation, in my o	ne, date and place, and pinion, death occurred a	due to the cause(s at the time, date an	s) and manner as stated. Indiplace, and due to the cause(s)
)	To th To th compl	Me	29b. Signature and title of certifiee	o Koles	29c. Licens D	e number 35436	29d. Da	ate signed (Month, Day, Year)
	T		30. Name and address of person who co	ompleted cause of death (Item 23)	A (Type Print) Barbar	ra Kalazny,	MPO	20852
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUL 18 20	32. Registrar's Signature	Sparle			

06-04917 Sandra Mitchell

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 24129

		1- For State Cell	rtificate of Death	Reg. No.	00 2912
Physici	an/	1 Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death
Medical Exami	ner	Sandra Mitchell		July 10, 2006	2247 hrs
		4a. Facility Name (if not institution, give street and number) Prince George's Hospital Center	4b. City, Town, or Location of Death Cheverly	h 4c. County of D Prince Geo	
		5. Social Security Number 6. Sex 7. Age (In yrs. I			-
Funeral Director	ŀ	570 00 0040	Months Days Hours Mir	— 1-	oreign Country) n.c.
		5 7 9 - 90 - 00 40 1 M 2 X F 46 Usual Residence of Decedent	Yrs.	Hay 25 1500	Oddritty)
any	ŀ		Town or Location		10d. Inside City Limits
<u>*</u> .	L	D.C. n/a Wa	ashington		1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What	Country?
MD 21215-0036 2 should be filed within 72 hours after death with the MaryJand h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	Öİr	4373 Dubois Place, S.E.	20019	U.S.A	
with ms 23	uneral	11. Marital Status 12. Was Decedent Ever in U	.S 13. Was Decedent of Hispanic Origin? (S		merican Indian, Black,
death or iten	ű	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	ii res, specily Cuball, Mexicall, Puello		
after ral", o	by F	Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify	opeany	Black
hours natu		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ref		ess/Industry
36 iin 72 : han '	ompleted	12th	Unemployed	n/a	
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medical	ĕ	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)	
215 e file tal Hy ked o	Be C	Charles Erwin	Franc	ces Moore	
21; ould b d Men s mar		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Number, City or Town, §	State, Zip Code)
Ore, MD 21215-0036 ages I and 2 should be filed within 72 ages I and 2 should be filed within 72 nt of Health and Mental Hygiene It: If item 27 is marked other than other traumatic event, the Medical other traumatic event, the Medical		Frances Jones/Mother	11003 Bolton St. 1		
ore, MD es I and 2 sh of Health an If item 27 i			Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - Cr	ty or Town, State
altimore, mit Pages I ar partment of Her portant: If ite			lenwood Cem. 7/	18/06 Wash.	DC
Baltimo permit Pag Department Important:		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	111 044	
@ 88 @	0. //	James E. Willeine	The House of Wi		
Physician /Medical		23a Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line	. Do not enter the mode of dying, such as cardiac	or respiratory arrest, snock, or heart	Approximate Interval Between Onset and
xaminer	i i	Immediate Cause (Final disease or condition resulting in death)			Death
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eve an a	//Medical	UNPENDED AMENDED			
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687 ertific ding p	au/		2 Fetal death 3 Ectopic pregn	nancy Month	Day Year
Box 68 e death certif the attending ed for use as	Physiciar	4 Pregnant at time of de 1 Yes 2 No 9 ✔ Unknown 9 Unknown	eath 5 Other (Specify)	- 4	
that the death certificate by the attending detached for use as:	Ph)	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacco use contribut	te to the cause of death?
, P.O.	J Q			1 Yes 2 No 3	Probably 4 Unknown
'ds, requir	Completed				re autopsy findings available
col e law e has l	μ			performed? dea	
tal Rection: The certificate		25. Was case referred to medical	26 Place of Death (Check		Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death and Therefore. The The The Therefore the funeral director, page 2 should be in by the funeral director, page 2 should be	o Be	examiner? [Hospital: 4 Inpetient 2 M	Other		Other.
n of V ling Phy After th funeral		1 Yes 2 No Impater 2 2 27. Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d Describe how injury occurred	
on on endin ath or: A he fur	tion	1 Natural 5 Pending Jul 10, 2006	2214 hrs 1 Yes 2 No	Subject stabbed	
r Atte rer de irecte n by t	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At h	ome, farm, street, factory, office building, etc.	28f Location (Street and Number of	or Rural Route Number, City
Divisior pital or Attendours after death neral Director: filled in by the	Certification:	4 Homicide determined (Specify) Single Far	nily	or Town, State) 4373 Duboise Place, Wash	nington, DC
Hos 24 h Fun tely		29a. Certifier Certifying Physician: To the best of my knowled	dge, death occurred at the time, date and place, an		
To the Howithin 24 Post To the Function Completely	Medical	one) 2 Medical Examiner: On the basis of examination a and manner stated			
_ / "	Ž	29b. Signature and title of certifier	29c. License number		(Month, Day, Year)
5		Calillas / 1	O.C.M.E.	July 11, 2006	
		30. Name and address of person who completed cause of death (Iten		1201	
		Zabiullah Ali, M.D. Assistant Medical Examine		1201	
S	tate	31. Date filed (Month, Day, Year) 4 2006 32. Registrar's Signat	il don't		

		1. Decedent's Name (First, I	Aiddle, Last,)							2. Date of	Death			3. Time	of Dea
hysicia		Albert	1.7		Mani	11i					Month July	12	Day 200	Year 06	6:50	a
/Medica xamine	-	4a. Facility Name (If not insti	tution, give	street and numi	ber)		4b. City,	Town, or	Location of	of Death				ty of Deat		
		Holy Cross	Hospi	tal			Sil	ver	Sprin	ıg				Mont	gomery	,
ineral		5. Social Security Number	6. Se	x 7] M 2 ☐ F	. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month)	Birth Day, Y	Year)	9. Birti	hplace (State	e or Fo
ector	-	528 -30-1419		- W 201	80	Yrs.					May	3,	1926	Wasl	hingto	n,
*	- H	Usual Residence of Decede 10a. State 10b. Co			10c. Ci	ty, Town or Lo	ocation								10d. Inside	City L
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	m	17. Father's Name (First, Mile										dle, Ma	aiden Suma	ame)		
a to	၉	Michele Ma				VIII.					Leli					
Tau a		19a. Informant's Name/Rela	tionship (7)	ype, Print)		19b. Maifii	ng Address	(Street a	and Numbe	er or Rura	al Route Nu	mber, (City or Tow	n, State, Z	Zip Code)	
hert	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location												Tour State			
Department of Health and Ments importent: if Item 27 is marked any injury or other traumatic a	20a. Method of Disposition 20b. Place of Disposition (Name of Date 17 20c. Location - City of Date 17											1 - City or	TOWIT, State			
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		•	For State Registrar	State of Ma		d / Dep		lealth and	Mental Hy	giene 006	24131
	Dhysiair		1. Decedent's Name (First, Middle, Last	•	-				2. Date of De Month		3. Time of Death
	Physicia /Medic		Walt	on	Re	eed	Mason		July	24, 2006	1824 P M
	Examin	_	4a. Facility Name (If not institution, give	street and number)				r Location of Deat	th	4c. County of Death	
_			Union Hospital				E1kto		0 D-14 Bi-	Ceci	
l,	Funeral Director		5. Social Security Number 6. Se 221-09-1925 1X	D	88 88	ast birthday) Yrs.	Months Days	Hours Min.		ay, Year) 9. Birm Cou 1918 Dela	place (State or Foreign ntry) AWATE
*	land ow		10a. State 10b. County		10c. City	, Town or Lo	ocation				10d. Inside City Limits
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	with the 3a or 284	Funeral Director	10e. Street and Number 186 Wood Valley R	oad			10f. Zip Code 2191	1		10g. Citizen of What Cou	,
	death	nera	11. Maritaf Status	12. Was Decedent I	Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No	14. Race - Ameri	
215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "naturel", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 擬 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🐼 N ff Yes, Give Year or Dates:	lo		1 Tes, specify Cub 1 ☐ Yes 2 ☑ No	Specify:	to Alcan, etc.)	Specify: White,	
2	72 ho	Completed	15. Decedent's Edi (Specify only highest grad	ucation		16a. Dece	dent's Usual Occup	pation during most of wo	nrkina	16b. Kind of Business/Ir	ndustry
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Mary	and and eum		19a. Informant's Name/Relationship (T)				_			er, City or Town, State, Zi	o Code)
≥ ~`	and ealth m 27		Henry W. Mason/S	on	005 0	_4	Shelton	Lane, Ri	-		
0	Fite or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	C	emetery, cre	osition (Name of matory or other pla		Date	20c. Location - City or T	
<u> </u>	ment tant: jury		4 ☐ Donation 5 ☐ Other (Specify,)	Fri				A	Calvert, Ma	ryland
Baltimore,	permit. Pages 1 and 2 should be Department of Heath and Menta Important: If item 27 is marked any Injury or other treumatic events.		21. Signature of Funeral Service Licens	3 Hul	w	$\overset{ ext{H}}{\overset{ ext{1}}{\vdash}}$	2. Name and Addre icks Home U3 W. Sto	ess of Facility for Fun ockton St	erals, E	P.A. on, MD 2192	I
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IIa	cian: ertific sctor,	Be (25. Was case referred to medical examiner?	(1	377	_			ath Check only	one)	
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Division of	anding Phasath. Sath. Spr. After this	atlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28b. Injury at Work?						how injury occurred	
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	To the Hospitel or Attending Physician: within 24 hours deler death and 17 to the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phyone) 2 ☐ Medical Example 1	ysicien: To the best iner: On the basis of and manner sta	examina	wiedge, dea tion and/or in	th occurred at the ti nvestigation, in my o	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and manner as s date and place, and due t	stated. o the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	ale M	-)	29c. Licens	3392	5	29d. Date signed (Month, 07/25/21	Day, Year)
	10		30. Name and address of person who co		eath (fter	0 /	Print) Str	eet R	wing Su	N MD 2	1911
	Sta Registr		31. Date filed (Month, Day, Year)	32. Hegistr			heele		0		

			1 - For State Registrar	State of M	farylaı			nt of F ate of			ental Hy	giene	7 11 11	6	24	132
	Physici /Medio	_	Decedent's Name (First, Middle, Last	Elieze	r PEI	EG					2. Date of Do Month July 1	Da	y Ye	ear	3. Time o	1.4
	Examir		4a. Facility Name (If not institution, give Montgomery Hospic 5. Social Security Number 6. Se	e Casey	House	last birthday	Ro	y, Town, o	lle		8. Date of Bi	40	County of C	omer		
	Funeral Director				55	Yrs.	Month		Hours	Min.	Nov. 3	ay, Year)	, ,	Count	ry)	or Foreign
	he Maryland 8e-f ehow	ector	10a. State 10b. County Maryland Montgom	ery	10c. C	Gait	hers									ity Limits 2∑No
	234 or 2	Funeral Director	30. Pavilion Drive				10f. 2	Zip Code 2087	78				tizen of Wha ael	t Count	ry?	
980	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of health and Mental Hygiane. Depertment of Health and Mental Hygiane. Importent: If Item 27 is marked other then "neturel", or Items 23s or 28s-f show employens: Injury goother treumatic event, the Medical Examinar must be notilised at once.	ରୁ	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 27 If Yes, Give Year or Dates	:?] No			edent of Heerity Cubi	lispanic O an, Mexica Specify		cify Yes or Ne Rican, etc.)	0-	14. Race - / Black, V Specify:		tc.	
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yland ?	ould be filed Mental Hyg warked othe	To Be C	17. Father's Name (First, Middle, Last) Yigael Fede	rgreen					J	udit	(First, Middle Rozine	r				
e, Mar	1 end 2 sh Health and em 27 is m ther treum		19a. Informant's Name/Relationship (T) Tamar Peleg, Wife 20a. Method of Disposition	rpe, Print)	20b.	30 Pa	v111	on Di	ive,	Gait	l Route Numb hersbu	rg,		0878		
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			Joseph Kaplan N	1.D., 600	1 Mur	ncaster	Mil		ad, R	ockvi	11e, M	D 2	.0855			
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			For State Registrer	State	of Man	yland	-			ealth a	and M	lental Hy	giene Reg. No.	2006	24	133
			1. Decedent's Name (First, Middle	, Last)								2. Date of D	aath Day	Year	3. Time of	
	Physicia /Medic		LILAWATI	PA	WAR							JULY 13	, 2006		5:30	P M
	Examin		4a. Facility Name (If not institution	give street and n	rum <i>ber)</i>					Location of	of Death			County of Death		
_			7305 SARA STREET 5. Social Security Number	6. Sex	7 Age //	In ure la	st birthday)		CARROI r 1 Year		24 Hrs.	8 Date of B		PRINCE GEO		or Foreign
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≍	8 to = 10		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		i	cer	metery, crei	matory or	other plac	1				·		
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Č	ing P	iuo]	27. Manner of Death 1 ☑Natural 5 ☐ Pendir	g (M	te of Injury lonth, Day Y	Year)	28b. Time o Injury	of M	28c. Injury Work	yat k? Yes 2. □		28d. Describe	how injur	y occurred		
isic	Attending Physician: ir death. ector: After this certification by the funeral director.	Certification:	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be 280 Blo	ace of Injury	v - At hor	me, farm, st			163 2	140	28f. Location	(Street an	d Number or Ru	ral Route Num	iber,
o S S	after after Direction by	erti	4 ☐ Homicide determ	bu	ılding, etc.	(Specify))		.,,				own, State			
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funarei Director: After this certificate he completely filled in by the Inneral director, page		29a. Certifier 1 Certifyir	g Physicien: To	the best of	my know	vledge, deat	h occurre	d at the tin	ne, date ar	nd place,	and due to th	e cause(s)	and manner as	stated.	
	in 24 in 24 in Etche Fit	edical	(Check only 2 Medical one)	Examiner: On the and m	anner state		on and/or in				ain occur	red at the time				i)
	Tot To t	Σ	29b. Signature and title of certifie	100001			market .	2	9c. Licens	e number			29d. Dat	te signed (Monti	, Day, Year)	
)	~		X	June 1					D42518	3			JULY	16, 2006		
			30. Name and address of person GUL CHABLANI, M.D.				KE. SUI	TE 40	L, ROC	KVILLE	, MAR	YLAND 20	852			
	Sta	ate	31. Date filed (Month, Day, Year)	32	Registrar			ale!	,		-					
	Regist		JUL 17	2005	BASI	J.T.	MA	- Carrie								

CCH	D/kds	1	For State Registrar		State of M	aryland				lealth a Death		Mental Hy	/gie	ene g. No. 20	06	241
	Physicia	n	Decedent's Name (First, Mi Normand	Ovi	,	au						2. Date of D		Day 2006	Year	3. Time of De 2:00
1	/Medica	U U	4a. Facility Name (If not institu	tion, give	street and number,)		4b. City,	Town, or	Location	of Death			4c. County	of Death	
	LAAttiiti		Prince George	e's I	Hospital (Center			Chev	erly				Pri	nce G	eorge's
	, Funeral Director		5. Social Security Number 038–18–7674	6. S	ex 7. A	ge (In yrs. la:	st birthday) Yrs.	If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of B (Month C Oct ±	irth ay, 1	1928	Coul	place (State or F ntry) de Islai
	T.		Usual Residence of Decedent									-04	1			0.1 1 0.7
	show		10a. State 10b. Cou		~ .		Town or Lo									I Od. Inside City
	the Mary 28a-f sh	ğ	MD Prin	ice (George's	For	estvi	ше						1 ☐ Yes 2		
	the M	Director	Oe. Street and Number 10f. Zip Code									10g. Citizen of Wh				ntry?
	hours after death with the Maryland uraf, or Itama 23e or 28e-f show al Ezar, fuer must be notified at		2007 Overton Drive 20747								_				USA	
		Funeral	11. Marital Status	t Ever in U.S	. 13.	Was Dece	dent of H	lispanic Or	igin? (Sp	pecify Yes or he Rican, etc.)	10-		ce - Ameri			
920		by	3 Widowed 4 Divorced Year or Dates:										Specia		ite	
r.	72 ho	eted	15. Dece (Specify only hi	dent's Ed ghest gra	ducation de completed)		16a. Dece (Give	dent's Usu kind of wo	al Occup	ation during mos	st of wor	king	10	6b. Kind of E	Business/In	dustry
121	within iene. r then	Completed	Elementary/Secondary (0-1	2)	Coflege (1-4or	5+)		er M		•				U.S.	Air :	Force
D	Hyg Hyg the nt,	d)	17. Father's Name (First, Mide	dle, Last))					18. Moth	er's Nan	ne (First, Midd	le, M	laiden Suma	me)	
Maryland	Mental	To B	Ovila			\mathbf{R}	ondea	ı		Eva	a Mi	llette		(+	Jnkno	wn)
2	Should Nod Not Nod Not Not Not Not Not Not Not Not Not Not		19a. Informant's Name/Relate	onship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					Code)				
Ž	Trans		Gisela Rondea	au (v	wife)		2007	Over	ton	Drive	e Fe	orestvi	.11	e, MD	207	47
(a)	1 ar Hea tam							b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town					own, State			
ē	Pages nent of int: if i		1 ☐ Burial 2 ☑ Cremati 4 ☐ Donation 5 ☐ Othe			θ	Crem	atory			20			Clinto	on, M	D
Baltimore	permit. Departminporta		21. Signature of Funeral Sen	2						ss of Facil		ee Fune Land Bl				vert, PA
		_	10	1	575	ad the death						or respiratory				Approximate

Physician /Medical

Examiner

à

Completed

Be

Certification;

Examiner

ysician and e burial-transit

the use as

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months?

9 Unknown

Immediate Cause (Final

disease or condition resulting in death)

23c. ff yes, outcome of pregnancy 1☐Live birth 2☐Fetal death

3 Ectopic pregnancy 4□Pregnant at time of death 5 Other (specify)

23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of):

Due to (or as a consequence of)

23d. Date of delivery Month Day

24a. Was an autopsy perform

28d. Describe how injury occurred

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Inknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2:00 P M

9. Birthplace (State or Foreign Rhode Island

Owings. MD 20736

Approximate Interval Between Onset and Death

Year

10d. Inside City Limits 1 Yes 2XXVo

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	rt

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No 3□ DOA 1 Inpatient

2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 🗌 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

Natural

2 ☐ Accident

3 T Suicide

4 Homicide

GARY

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and the of certifier

5 Pending

investigation

6 Could not be determined

29c. License number

29d Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL

State Registrar

31. Date filed (Month, Day, Year) JUL 1 9 2006

LIME

32. Registrar's Signature

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director.

			State of Maryland / Depart	tment of Health and Me	ental Hygie	2006	21.135
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	No UUD	3. Time of Death
	Physici		Charles W. Robinson			5°, 2006	3:50A. M
ł	/Medio Examin		4a. Facility Name (If not institution, give street and number) 4	b. City, Town, or Location of Death		4c. County of Death Montgomery	,
Ī	Funeral Director			If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month Day, Y April 28, 1	9. Birthp Cour Washi	lace (State or Foreign lity) .ngton, D.C.
	and w.		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Local	tion		1	0d. Inside City Limits
	ne Maryla Ba-f eho	ctor	Maryland Montgomery Silver S	pring			1 ☐ Yes 2 X No
	th with the 23a or 2 list be no	ai Dire	109. Street and Number 12340 Pretoria Drive	10f. Zip Code 20904		. Citizen of What Cour Inited Stat	
036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "naturel", or Items 23a or 28a-f show imatic event, the Madical Examinar naid be notified at	by Funeral Director	1 Never Married 2 Married 1 XIVes 2 No	is Decedent of Hispanic Origin? (Speces, specify Cuban, Mexican, Puerto R	city Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify:	
Maryland 21215-0036	ithin 72 ho ne. nen "natur Medical	Completed	(Specify only highest grade completed) (Give kin life. DO	nt's Usual Occupation nd of work done during most of workin NOT use retired) Strator)g	b. Kind of Business/Inc	-
2	filed w Hygier Sther th	S	17. Father's Name (First, Middle, Last)	18. Mother's Name			.i tilleli t
ylanc	ould be fi Mental It arked of attic ever	To Be	John L. Robinson	Ruth Aug	gusta	Ric	hmond
Mar	nd 2 sho alth and 27 is m		19a. Informant's Name/Relationship (Type, Print) Jewel O. Robinson -wife 12340	Address (Street and Number or Rural Pretoria Drive Si	Route Number, C Llver Spr	City or Town, State, Zip Fing, Maryl	.and 20904
nore,	ages 1 a		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, cremate Metropolit	ion (Name of tory or other place) an Crematory 7/17		exandria.	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any Injury or other treumatic ev once.		21. Signature of Funeral Service Licensee	Vame and Address of Facility and t	Funeral	Home, PA	
	40244		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	O Powder Mill Ros			Approximate
)	Physician		Immediate Cause (Final disease or condition a Congestive Heart Faceulties in death)				Interval Between Onset and Death
ı	/Medical Examiner		Sequentially list conditions Hypertension				
	uted d ansit	Examiner	rit any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
760,	ie be executed ysicien and e burial-transit	cal Exa	resulting in death) Last Due to (or as a consequence of):				
687	ficate p phys ss the		d				
Division of Vital Records, P.O. Box	Hospital or Attending Physicien: The law requires that the death certificate be executed to hours effer death. Funeral Director: After this certificate has been signed by the ettending physicien and telleral Director: After this certificate has been signed by the ettending physicien and teller tilled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Med		ctopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
۳.	res thet if igned by be detac	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
ords	w requires been sign should be	ted b	Renal failure; Diabetes; Chronic Obst	ructive Pulmonary	1 ☐ Yes	2□No 3□Prob	oably 4\times\unknown
Rec	he law r e has be age 2 sh	Completed	Disorder; Hypothyroidism		24a. Was an autopsy performe	prior to co.	psy findings available mpletion of cause of
<u>t</u> a	en: T rificet tor, pa	0	25. Was case referred to medical	26. Place of Death		ŽIVO ILLIES	2 NO
<u>></u>	hysici his ce I direc	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient		ne 5ሺ Residen	ce 6 □Other (Specif	у)
o uo	ding PI h. After ti funera		27. Magner of Death 1 ⚠ Natural 5 ☐ Pending investigation 28a. Date of Injury (Month, Day Year) 2 ☐ Accident investigation	28c. Injury at Work? M 1 Yes 2 No	8d. Describe how	injury occurred	
)ivisi	To the Hospital or Attending Physicien: The law within 24 hours effer death. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)		28f. Location (Stre City or Town,	et and Number or Rura State)	J Route Number,
	Hospital 4 hours e Funeral I ely filled		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigations)	occurred at the time, date and place, a stigation, in my opinion, death occurre	and due to the cau	se(s) and manner as s	tated.
	ithin 2 o the to	Medicai	one) and manner stated. 29b. Signature and title of certifies	29c. License number	290	I. Date signed (Month,	Day, Year)
	10		I fruiter clouded	D02338		July 17, 2	2006
	. ~		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr Richard P. Delaney, M.D. 3929 Ferrara	Drive Wheaton, Ma	aryland 2	20906	
t	Sta Regist		31. Date filed (Month, Day, Year) 32. Projectar's Signature	sele!			

			State of Maryland / Department of Health and Months of Health and Health and Months of Health and He		ene 0 0 6	24137							
	Physici		1. Decedent's Name (First, Middle, Last) John Earl Rudder	2. Date of Death Month July	9°, 2006°	3. Time of Death 12:30P M							
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Collingswood Nursing Home 4b. City, Town, or Location of Death Rockville		4c. County of Death Montgo								
	Funeral Director		5 Social Security Number 401–26–9738 6. Sex. 128M 2 F 7. Age (In yrs. last birthday) 81 Yrs. 1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You Oct. 4,		place (State or Foreign intry) ucah, KY							
ore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 le marked other then "naturel", or Items 23e or 23e-f show any injuryor other treumetic event, If a Medical Examinat must be netified at any injuryor other treumetic event, If a Medical Examinat must be netified at any injuryor other.	To Be Completed by Funeral Director	1 Rurial 2 Cramation 3 Removal from State cemetery, crematory or other place)	city Yes or No-Rican, etc.) 16 (First, Middle, Ma. e Copela. 17 Route Number, Cle, MD 2	ib. Kind of Business/li Buffalo Taxi Comg iden Sumame) nd - Rudde City or Town, State, Zi	ican Indian, etc. ican America ndustry pany p Code)							
Baltimore,	permit. Page Department of Important: If any injury or		'4 X Donation 5 Other (Specify) Howard Medical Sch. 7/1	stin Roys W Washir	-	al Home							
8760,	Physician /Medical Examiner behavioral and physician and street behavioral transit	cal Examiner	shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Shock or heart failure. List only one cause on each line. Bronchitis Due to (or as a consequence of): Diabetes Mellitus Due to (or as a consequence of): C. Hypertension Due to (or as a consequence of): d.			Interval Between Onset and Death 3 Weeks 15 Years 15 Years							
.O. Box 68	death certif e attending d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of deliv	ery Day Year							
S,	w requires that the sbeen signed by the should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia, Prostate Cancer		cco use contribute to t								
tal Reco	The law ate has b page 2 sl	e Completed by	25. Was case referred to medical 26 Place of Death	24a. Was an autopsy performed	prior to co	opsy findings available impletion of cause of							
Division of Vital Record	ding Phye h. After this funeral di	Certification: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 2 Switches 6 Could not be	ne 5 Residenc 8d. Describe how	et and Number or Run								
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number	d at the time, date	se(s) and manner as s and place, and due t Date signed (Month,	o the cause(s)							
)	6		29b. Signature and title of certifier 29c. License number D0053615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		July 17, 2								
			Dr. Aruna Nathan, 11125 Rockville Pike Suite 208	Rockvill	le, MD 208	51							
	Sta Registr		31. Date filed (Month, Day, Year) JUL 18 2006 32 Registrar's Signature										

			1 - For State Registrar	State of Maryla		artment of			ntal Hygie	2000	24138
	Physic /Medi		Decedent's Name (First, Middle, Last, Linda)			gieri	2	. Date of Death Month	Day Year 2006	3. Time of Death
	Examir		4a. Facility Name (If not institution, give 10009 Apple Hill 5. Social Security Number 6. Se	Court	n last hirthday	4b. City, Town, Potoma	ac	of Death		4c. County of Dea Montgon	nery
	Funeral Director		013.01.5591 Usual Residence of Decedent	□M 2[X]F 9	s. last birthday, 3 Yrs.	Months Days		Min.	Date of Birth (Month, Day, Ye OV.30, 19	912 Rhoc	thplace (State or Foreign puntry) le Island
	he Marylar 28a-f show	Director	MD 10b. County Montgo		tomac						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with t	ai Dir	10e. Street and Number 10009 Apple Hill	Court		10f. Zip Code 208.			10g.	U.S.A.	ountry?
980	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23e or 28e-f show mortant: In Item 27 is marked other than "natural", or Iteme 23e or 28e-f show any in the Medical Examinar must be notified at ance.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 No			y Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify:	encan Indian, re, etc. White
Maryland 21215-0036	within 72 ho ane. than "natur he Wedical S	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retir	e durina mosi	t of working	16b	. Kind of Business	
land 2	uld be filed v dental Hygie rked other i tic event, II	To Be Co	17. Father's Name (First, Middle, Last) Nicola DiDomeni	.co	no	omemaker	18. Mothe		First, Middle, Maid Letta Rac	,	ome
Mary	nd 2 sho lith and A 27 is ma r traume	r i	19a. Informant's Name/Relationship (Ty Mary Ann Krause/ I		19b. Maili 10009	ng Address <i>(Stree</i> Apple I	at and Numbe	or Rural F	Route Number, Cit Potomac,	ty or Town, State, 2	
Baltimore,	Peges 1 and neut of Hear int: If Item		20a. Method of Disposition 1X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	lemoval from State	Place of Dispo cemetery, create te of H	osition (Name of matory or other pla leaven		Date uly 15	-	Location - City or	
Balt	permit. Departn Imports eny Inju		21. Signature of Fun ral Service Licens	Lead	51	30 Wisco	onsin A	Avenue	NW WDC	r's Sons, 20016	Inc.
}	Physician		23a. Part1 Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the declerations cause on each line. Cerebra1				cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death 5 days
	/Medical Examiner	er	Sequentially list conditions	Due to (or as a conse Myocardia Due to (or as a conse	1 Infar	ction					5 days
8/60,	cate be executed physicien and the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Atriafibr Due to (or as a conse	quence of):						
0	sertificate ding phys se as the	/Medical	IF FEMALE:	3c. If yes, outcome of pregr		<u> </u>					****
O. Box	The law requires that the death certific te hes been signed by the attending r age 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12-months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fei 4 Pregnant at time of 9 Unknown	aldeath 3	Ectopic pregnand Other (specify)	су			23d. Date of deli Month	ivery Day Year
Records, P.	w requires that been signed to should be deta	ted by P	Part II. Other significant conditions cor Hypertension, Typ				iven in Part I.				the cause of death?
		Completed							24a. Was an autopsy performed?	death?	topsy findings available completion of cause of 2 No
VITA	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	TER/Outpotion	nt 3 DOA Ot			Check only one	6 □Other (Spec	
ion of	ding h. After fune	!	27. Manner of Death 1 \(\sum \) Natural 5 \(\sum \) Pending investigation	28a. Date of Injury (Month, Day Year)	f 28c. Inju	ury at ork?	280	Describe how in		uty)	
DIVISION	o Hospital or Atten 24 hours after deat 2 Funeral Director; etely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f.	Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dircompletely filled in I	Medicai	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deatl ation and/or in	h occurred at the t vestigation, in my	ime, date and opinion, deat	d place, and th occurred	due to the cause at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the To the Complet	M	29b. Signature and title of certifier When I	lee mp			se number			Date signed (Month	,
			30. Name and address of person who co Albert K. Lee, M	mpleted cause of death (Ite		Print)		105	Bethesd		0814-3107
	Sta Registr	-	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	ulis					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July **Physician** Rickerd Michelle Lynn 2006 4:06 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Nov. 22, 1 Frederick Frederick Memorial Hospital 9. Birthplace (State or Foreign Country)
D • C • 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Director 225-47-9559 31 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Iteme 23s or 28s-f ahow 1 ☐ Yes 2 ☐ No Director Maryland Frederick Thurmont 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 307 Eyler Road 21788 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo δ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygient (Important: If Item 27 is marked other withen eny Injury or other traumation..... Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Aspen Publishers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Michael Joseph Moroz Barbara Johanson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin E. Rickerd / Husband 307 Eyler Road, Thurmont, Maryland 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg Crematory 7/21/06 Smithsburg, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatur Fneral Service Licent ROBERT E. DATLEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN ST., THURMONT, MD 21788 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one earse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Respiratory /Medical Due to (or as a consequence of): Examiner Due to (or s a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Il-transit Attending Phyaician: The law requires that the death certificate be executed physicien ar Due to (or as a consequence of) O. Box 68760, Physician/Medical as attending ; IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 □Ectopic pregnancy Month Day signed by the at Id be detached fo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24b. Were aulopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes autopsy performed? this certificate 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? director, 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Impatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this campletely filled in by the funeral is 27. Manner of Death Certification: 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1: Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32245 onen 30. Name and address of/person who completed cause of death (Item 23a) (Type, Print) get De. Any Jo 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #10a-f&17 Per INF 859 9/19/06 Jh
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Evelyn Lillian Ruesen July 22 2006 7:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1216 Lake Forest Drive Davidsonville Anne Arundel If Under 1 Year | If Under 24 Hrs. | 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth __(Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 1 ☐ M 2 🖫 F 81 Yrs. Director 147-16-2402 Feb.16,1925 New Jersev Usual Residence of Decedent permit. Pages 1 end 2 should-be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: If item 27 is marked other then "netural", or iteme 23s or 28s-f show any injury or other treumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Grove Monmouth 10d. Inside City Limits 1 ☐ Yes 2 🗓 No Director Maryland Anne Arundel Davidsonville 36 MCLintock Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 07756 1216 Lake Forest Drive 21035 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chemist Commercial Lab 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Paul Ruesen Paul Eugene Ruesen Lillian Louise Federolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Strauss / Daughter 1216 Lake Forest Drive, Davidsonville, MD 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 07-24-06 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Function 2973 Solomons Island Rd., Edgewater, MD 21037 0 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** acro disease or condition resulting in death) 1 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner \mathcal{J} the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours story doors. use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. Physiclan/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 cete has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2K) No 1 Yes 2□ No 1 Yes After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Daughter's Other: Medical Certification; To 4 ☐ Nursing Home 5 ☐ Residence 6 ②Cother (Specify) Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 □ Yes 2 □ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 167 1200e 32. Registrar's Signature State Registrar

		1	For State Registrar	State	e of Maryla		artment of F		and Mer		ene g. No. 00	6	2411	L _k
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}	Examin		4a. Facility Name (If not institution	on, give street and	d number)		4b. City, Town, o	r Location o	of Death		4c. County	of Death		
			17901 Red Rock				German		D4 Hzg. La	5 (5:4		tgom		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔀		rs. last birthday) Q/, Yrs.	If Under 1 Year Months Days	If Under	Min. T.	Date of Birth (Month, Day, une 6,	Year) 1922	e. Birthic Coul		r r-oreign
	Director		578-46-7861 Usual Residence of Decedent			84 Yrs.			J	une o,	1922	Can	aua	
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Maryland	Shoul nd Me marl marl	F	19a. Informant's Name/Relation	nship (Type, Print)	19b. Mail	ng Address (Street	and Number	er or Rural R	Route Number,	City or Town,	State, Zip	Code)	
Š	nd 2 allth a 27 ls		Richard Speig	e1 / Son		17901	Red Rock	ks Dri	ive; G	ermant	own, Ma	aryla	nd 208	74
Je,	of Hear Itam		20a. Method of Disposition	2 Demond		p. Place of Disp cemetery, cre	osition (Name of matory or other pla	ice)	Date	9	20c. Location -	City or T	own, State	
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D	after after Dira	Certification:	4 Homicide		building, etc. (Sp	ecity)				City or Town	n, State)			
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 🔀 Certif	ying Physician:	To the best of my	knowledge, dea	ath occurred at the investigation, in my	time, date a	nd place, an	d due to the c	ause(s) and m	anner as	stated.	s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Amend Item #5 State of Maryl State Registrar WCHD/SH 7/19/06 per FH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Ray Eugene Shoemaker, Sr. 0821 AM 3 W/4 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 02/20/1942 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min 1X M 2 ☐ F 64 741-85-5737 MDDirector Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No MDWashington Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 US 131 E. Franklin Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖫 No White Specify: Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 1.0 Manufacturing Assembly Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental F litem 27 is marked of r other traumatic ever Samuel Richard Shoemaker Margaret Pauline Pike 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray E. Shoemaker, Jr. / Son 16840 Calvary Drive, Williamsport, MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ō <u>=</u> 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If eny Injury or once. Cedar Lawn Mem. Park 07/18/2006 Hagerstown, MD 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 -23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? ontributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 Yes 2 No Sathin 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No **ER/Outpatient** 3 DOA 27. Magner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signal ertifier STEPHEN E 31. Date filed (Month, Day, Year) State 2006 Registrar

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Maryland / Department of Health and Mental Hygiene	Same Total	-7 U

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	-		Decedent's Name (First, Middle, Last)		2. Date of Dear		3. Time of Death						
Н	Physicia		Joyce S. Shankman				July 1		3:00 A. M				
R	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of	Death				
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year Months Days	Hours Min	8. Date of Birth (Month, Day)	Year)	Birthplace (State or Foreign Country) New York				
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	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H	ispanic Origin? (Spe n, Mexican, Puerto F	city Yes or No-		American Indian, White, etc.				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Itsm 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinin must be notified at once.	by Ful	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	Yes 25 No	Specify:	iloan, sto.)		Specify: White					
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89	ifficate g phy as the	-											
Вох	death certif e attending id for use a	N/	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal de		23d. Date of delivery								
0	ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at time of death		Month Day Year								
P.O.	that the de ed by the a detached	Phy	9 Unknown	230 Did to	id tobacco use contribute to the cause of death?								
	8 E 9	þ	Part II. Other significant conditions contributing to death but not resultin Atrial Fibrillation	en in Part I.		□ Probably 4½ Unknown							
Records,	w requir been si should	Completed	Diabetes Mellitus										
3ec	e la has je 2	шр	Diabetes Heilitus	sy pri	24b. Were autopsy findings available prior to completion of cause of death?								
a	ian: The I rtificete ha	- 1		2 No 1 □]Yes 2□No								
Ξ	3 8 6	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☑ Inpatient 2 ☐ EP.	Outpation	t 3 DOA Oth	er: 4 Nursing Hon	e 5 ☐ Residence 6 ☐ Other (Specify)						
o		1.7	27. Manner of Death 28a. Date of Injury 28	b. Time of	28c. Injur			Describe how injury occurred					
ion	Attanding for death.	ation	1 🖾 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation										
Division of Vital		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	eet, factory, office			n (Street and Number or Rural Route Number, Town, State)						
۵	ital or ars afte ral Dir led in												
	To the Hospital o within 24 hours aft To the Funeral Discompletely filled in	Medicai	29a. Certifier (Check only one) 29a. Certifier (Check only one) Check only one Check										
	Mithin 2	Mec	29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date signed	(Month, Day, Year)				
)			Mayora up			July 17, 2006							
as the state of assess who completed across of death (from 23a) (Type Brigh)							000						
			Suresh K. Gupta, MD PA 9801 Geor	gia A	ve. Ste2	-20 Silve	r Sprin	g, MD 20	902				
	Sta												
3	Regist	ar	31. Date filed (Month, Day, Year) 32 Registrar's Signature ### Signature ### Signature ### Signature	April									

			For State Registrar	State of	f Marylar	-	artmen tificate			and M	lental Hy	/giene	3 B B B	24144	
ı	Physicia		1. Decedent's Name (First, Middle Melvin Joseph S	,				·			2. Date of Do Month July	eath Day		3. Time of Death 3:26 p M	
П	/Medic Examin		4a. Facility Name (If not institution		nber)		4b. City,	Town, or	Location o		July		. County of Deat		
	LXUIIIII	٠.	Loch Raven Cent	er			Park	vill	.e			В	altimor	e	
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 □ F	7. Age (In yrs.		If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Bi (Month, D	ay, Year)	Co	hplace (State or Foreign	
l.	Director		213-05-4780 Usual Residence of Decedent	10 14 201	89	Yrs.					12/21/	1916	Mar	yland	
	iand ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits	
	Man)	tor	Maryland Baltim	ore	Par	kville								1X Yes 2 □ No	
	th the or 28a)irec	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What Co	untry?	
	ath w	ral	4102 Prior Ave.					1206					ted Sta		
	ltems	Funeral Director	11. Marital Status 1 □ Never Married 2 🕅 Marri	Armed Fo		J.S. 13.	Was Deced f Yes, spec	ent of Hi ify Cuba	spanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, White		
336	urs aft	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	9		1□Yes 2	No Mo	Specify:				Specify: Whi	te	
9	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or tems 23a or 28a-f show event, it e Madical Examination ust be notified at	ted	15. Decedent (Specify only highes			16a. Deced	dent's Usua kind of wor	l Occupa	ation	of worki	na	16b. K	ind of Business/	Industry	
21	ithin 7 ne.	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	Bethle	e hem	e retired. Stee)	or works	9	Stee	el Mill	/	
2	lled w lygier her th		8 17. Father's Name (First, Middle, I	acti		Trans	porta	tion		r's Name	(First, Middle		pyard		
and	ould be fi Mental H arked of atic eval	Be c		_431/					TO. WICKING	i 3 Name			Sumanne)		
Baltimore, Maryland 21215-0036	es 1 and 2 should be filed w of Health and Mental Hygier If itam 27 is marked other ti rr other traumatic evant, IL.	To	Ernest Smith 19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	or or Rura		er, City o	or Town, State, 2	Zip Code)	
E ≥	and 2 ealth ar n 27 is		Jeffrey Smith/S	on		4102	Prior	Ave	., Ba	altin	nore, M	1D 2	1206		
č.	of Hear		20a. Method of Disposition 1 Darial 2 Dicremation	2 Demoved from	20b. I	Place of Dispo	sition (Nam natory or o	ne of ther place	θ)		ate	20c. Lo	ocation - City or	Town, State	
Ē	Pages nent of ant: ff it ury or o		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Si		State	esapeal			i	/19/	2006	Belt	tsville,	Maryland	
3alt	permit. Page Department of Important: if any injury of once.		21. Signature of Funeral Service	icensee		22 Tł	. Name and	d Addres	s of Facilit	y arv	Servic	e.P.	. A .		
	₫ O E # 04		23a, Part1. Enter the disease, or	u_		193	33 Gis	st A	ve.,	LL,	Silver	Spr	ing, MD	20910 Approximate	
8			shock, or heart failure. List	only one cause on e	ach line.	inj. Do not ent	er the mode	a or ayırıç	g, such as	cardiac	or respiratory a	arrest,		Interval Between Onset and Death	
F	nysician /Medical	H	disease or condition resulting in death)		Cance or as a consec										
	Examiner			Cone			Faile	ira							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					L rallure							
	acuted ind transi	Examiner													
90,	be executed sician and burial-transit		resulting in death) Last	quence of):											
68760	physi s the t	dlcal		d											
o X	eath certific attending p	υ/Me	IF FEMALE: 23b. Was decedent pregnant	23b. Was decedent prograph 23c. If yes, outcome of pregnancy									23d. Date of delivery		
. D m D i i l l Yes 21 INO								Month							
o.	at the de by the a	hys	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
ń.	The law requires that the te has been signed by thi sage 2 should be detache	by									the cause of death?				
Örc	w requir been si should	Completed										:			
3ec	The law cate has t page 2 s	mp								24a. Was an autopsy performed		24b. Were autopsy findings available prior to completion of cause of death?			
<u> </u>	i icien: Th certificate rector, pag	e Co	25. Was case referred to medical					- "	26 Place	of Dooth	1 ☐ Yes	2 X No	1 □ Yes	2 ∑ No	
>	ysicien: is certific director,	o B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 🗆 I	npatient 2] ER/Outpatien	it 3 DO	A Othe					6 □Other (Spec	cify)	
סר	ding Phy h. After this funeral c	T inc	27. Manner of Death 1 X Natural 5 ☐ Pendin	28a. Date of	of Injury th, Day Year)	28b. Time of Injury	2	8c. Injury Work	at			8d. Describe how injury occurred			
Sio	endir eath. or: Af	catic	2 Accident investigation M 1 Yes							es 2 No					
Division of Vital Records,	iel or Attending Physicien: T s after death. al Diractor: After this certificat ed in by the funeral director, ps	Certification	3 ☐ Suicide 6 ☐ Could r 4 ☐ Hornicide determ	ned 288. Place	of Injury - At h ng, etc. <i>(Speci</i>	ome, farm, str fy)	eet, factory	, office		:		(Street an wn, State		ral Route Number,	
	Hospitel 4 hours a Funaral [tely filled		29a. Certifier 1 📉 Certifyin	g Physician: To the	hest of my kni	nwiedge death	n occurred :	at the tim	e date an	d place a	and due to the	ralise(s)	and manner as	stated	
	To the Hospitel or within 24 hours afte To tha Funaral Director Completely filled in the	edical		Examiner: On the ba											
	To the I within 2 To tha I complet	Me	29b. Signature and tipe of certifier				29c	. License	number				te signed (Monti	h, Day, Year)	
6			I hadre.						123	64	2	7/16	5/2006		
			30. Name and address of person							100	21220				
13	C		Xiao Zhou 5 31. Date filed (Month, Day, Year)	601 Loch				a⊥ t i	more,		21239				
	Sta Registr		JUL 18	2006	egistrar's Sign	K Ap	all!								

			1 - For State Registrar	State of Marylar	-	artment of F			ene i. No. 2 N	0.0	21.115
ĺ	Physic /Medi		Decedent's Name (First, Middle, Last) HANNA SHANDER					2. Date of Death Month July	P3, 2	2006	3. Time of Death 12:35 P.M
)	Exami		4a. Fecility Name (If not institution, give s Arcola Health & F		n Ctr.		Spring	h	4c. County of		
I	Funeral Director		102 40 7014	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Y	°°°1911	9. Birthpla Countr New	ace (State or Foreign Y) York, N. Y
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G		ty, Town or Lo	cation				10	d. Inside City Limits
	th with the 23s or 28s	Funeral Director	10e. Street and Number 12404 Mt. Pleasant	Drive		10f. Zip Code 20708		10g	. Citizen of W	hat Countr	y?
030	n 72 hours after death with the Maryland *natural', or Itams 23a or 28a-f ahow palical Examinar mat be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	Black	- America , White, et Whit	tc.
1215-0036	filed within 72 ho Hygiene. ther then *natur int, the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 Years	cation a completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired retary	ation during most of wor l)	rking 16	b. Kind of Bus		istry
ylandz	0 = 0 5	To Be Co	17. Father's Name (First, Middle, Last) Louis Mishkin					ne (First, Middle, Ma ne Mosevit)	
е, маг	permit. Peges 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic e once.		19a. Informant's Name/Relationship (Type Linda Spevack - D 20a. Method of Disposition	aughter	12404	Mt. Plea	asant Dri	ral Route Number, C Lve, Laure Date 20	1, Mar	y1and	20708
saitimore,	nit. Peges entment of ortant: If it injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Ce	dar Pa	sition (Name of natory or other place rk Cemete Name and Addres	ry 7-16	5-2006 P		, New	Jersey
Ö	Depermine Deperm		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	tottlement				Memorial , Rockvil			20852
)	Cate be executed have cate be executed by Medical Examiner the purish transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a))).	uence of):						nterval Between Onset and Death
YOU .	death certiff e attending id for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Gc. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery	, ay Year
COIDS, T.	Physician: The law requires that the this certificete has been signed by the rail director, page 2 should be detached.		Part II. Other significant conditions conditions Coronary Artery D		ulting in the ur	derlying cause give	in in Part I.		co use contrib		cause of death?
שרו ומ	i: The law re icete hes be i, page 2 sho	Completed						24a. Was an autopsy performed	1? de	ere autops or to comp ath? Yes 2	y findings available of No
<u>:</u>	/sicie. s certif directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	2 DOA Othe		th Check only one		<i>(</i> 0 <i>(</i> -)	
	To the Hospital or Attending Physicien: The law within 24 hours effer death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	atlon; T	27. Magner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. injury Work	at ? 'es 2 No	28d. Describe how	njury occurred	(Зреспу)	
Š	To the Hospital or Attending within 24 hours efter deeth. To the Funeral Director: After completely filled in by the funer	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - At he building, etc. (Specifical Control of the control of	v) 			28f. Location (Stree City or Town, S	tate)		
	ha Mos n 24 ho na Fund bletely f	edical	29a. Certifier (Check only one) 1 Certifying Physical Certifying Physical Examin	ician: To the best of my kno ar: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tim estigation, in my op	e, date and place, inion, death occur	and due to the caus red at the time, date	e(s) and manr and place, an	ner as state d due to th	ed. ne cause(s)
	To # To # Comp	M	29b. Signature and title of certifier	Segal	7 mp		number		Date signed (
			30. Name and address of person who con Alan R. Segal, M.	D. 1517 Hugo	Circl	,	Spring	Maryland	2090	6	
	Sta		31. Date filed (Month_Day, Year)	32 Registrar's Signa	ture do	weed .					

		1 - For State Registrar	State of Maryla	nd / Dep	artmei		ealth ai		ygien Reg. No	e 2006	24	146
Physic /Med Exami	ical	Decedent's Name (First, Middle, La. Ruth Ward Schue Aa. Fecility Name (If not institution, give Montgomery General	etzle e street and number)		4b. City		Location of	July 1	O, Da	2006 County of Dea Montg	9:5	OA. M
Funera Director		5. Social Security Number 218 – 38 – 7984 1 Usual Residence of Decedent 10a. State 10b. County	□м ЖД	9 Yrs.	Months	Days	If Under 24 Hours	Min. Oct. 23	inth 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	9. Bir	ew Yor	
21215-0036 2 within 72 hours after death with the Maryland piene. If then "natural, or iteme 23a or 28a-f show the Macical Examiner mante natified at	Funeral Director	Maryland Prince (10e. Street and Number 6213 Seminole Pla	George's Col	lege Pa	ark	p Code 2074()			itizen of What C	1\(\overline{X}\) Y ountry?	e City Limits Yes 2 ☐ No
036 ours after death irai', or iteme 2:	b	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in t Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1943-		Was Dece If Yes, spe 1 Yes		spanic Origin, Mexican, Specify:	n? (Specify Yes or N Puerto Rican, etc.)	L.,	14. Race - Ame Black, Whi	erican Indian	1,
O = = =	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12. Father's Name (First, Middle, Last)	College (1-4or 5+)	16a. Dece (Give life. Cryp	kind of w	ork done d use retired)	uring most o		Fe	deral G		ient
ryland though the filed Mental Hyge marked other matic event,	To Be	W. Earl 19a. Informant's Name/Relationship (Ward	19h Maili	nn Addres	s (Street a	Mabel	s Name (First, Middl or Rural Route Num			Wilco	X
		Albert A. Schuetz	le -husband	6213 Place of Dispo	Semi	nole	Place	College	Park	, Maryla ocation - City or	and 20	
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta important: If them 27 is marked eny injury or other traumatic enone.		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licer	Me	tropol:	itan Snard	Crema	itory Sorewa	7/12/2006 rdt Funer Road Bel	Ale al He	exandria	a, Vir	ginia
BOX 68760, eath certificate be executed with the same attending physician and for use as the burial-transit	Ical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Urinary T. Due to (or as a consect of the cons	an Syst quence of): quence of): ract In	tem F	ailur		irulac or respiratory	arrest,		Approxii Interval I Onset ar	Between nd Death
. D O D	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12-gronths? 1 □ Yes 2 ØNo 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 6 9 □ Unknown	aideath 3	⊒Ectopic p] Other (s					23d. Date of de Month	livery Day	Year
	b	Part II. Other significant conditions condentia	ontributing to death but not re	sulting in the u	nderlying	cause give	n in Part I.		tobacco Yes 2	use contribute to	the cause of	
Rec The law The has to	e Completed	25. Was case relerred to medical						perl 1 ☐ Yes	opsy ormed? 2X No	24b. Were at prior to death?	utopsy findin completion o	gs available if cause of
on of ding Phyen. After this funeral dia	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 28a Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		28c. Injury Work	r: 4 □ Nurs at	ing Home 5 Res 28d. Describe	idence		cify)	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	building, etc. (Speci	fy)				City or To	own, State			'umber,
To the Hospital within 24 hours a To the Funeral Completely filled	ledical	one) 2 Medical Exam	ysician: To the best of my kni illier: On the basis of examination and manner stated.	owledge, deatl ation and/or in	vestigation	n, in my op	inion, death	place, and due to the occurred at the time	, date an	d place, and due	to the caus	
So To Con Con Con Con Con Con Con Con Con Co	×	29b. Signature and title of certifier 30. Name and dress of person who	Completed cause of death //sc	n 23a) /Tuna		c. License DOC	number 61681			te signed (Mont Ly 11, 2	-)
		Robert Kircaldy, 31. Date filed (Month, Day, Year)	M.D. 18101 Pr	ince Pl	hilir	Driv	7e 01m	cy, Maryl	and .	20832		
Regis	ate trar		006	B. Go	este)							

			For State Registrar	State of Mar	•	epartment of F Certificate of			ne .No. 2006	24147
I	Physici		1. Decedent's Name (First, Middle, Las Adonis T.	stanford				2. Date of Death Month July	Day 2006	3. Time of Death 7:36 ^a M
	/Medic Examin		4a. Facility Name (If not institution, give Baltimore Washing	street and number)	al	4b. City, Town, o	r Location of Death		4c. County of Deeth Anne Aru	<u> </u>
Ì	Funeral Director		5. Social Security Number 6. Se	7. Age ((In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You June 29	9. Birth Cou	
	Aaryland I show	or	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the h	Funeral Director	MD Anne Arn 10e. Street and Number 403 Sandera Dr.	indel	Gam	orills 10f. Zip Code 21054	1	10g.	. Citizen of What Cou	
9	rs after deat i', or Itams 2 reminer mu	by Funer	11. Marital Status ¹☼ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Spec an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: R1	
C00-C171	s 1 and 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Exertinal must be nutified at	Completed t	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	ucation	(C	ecedent's Usual Occup ive kind of work done e. DO NOT use retired	durina most of workin	161	b. Kind of Business/In	
and z	should be filed with nd Mental Hygiene marked other tha matic event, the	o Be Co	12 17. Father's Name (First, Middle, Last) Airmond Stanford		D.	isabled	18. Mother's Name Brenda	(First, Middle, Mai		
-	1 and 2 shou Health and M tem 27 is mar		19a. Informant's Name/Relationship (7 Brenda J. Kim/Moth		403	ailing Address (Street Sandera Di		Route Number, C	ity or Town, State, Zip 21054	Code)
ש	permit. Pages 1 Department of He Important: If Iten any injury or oth		20a. Method of Disposition 1 ☐ Burial 2℃ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify)	cemetery,	sposition (Name of crematory or other place rematory	7/18/	2006 Ва	altimore, M	d.
Da	Depar Depar Impor		21. Signature of Funeral Service Licen 23a. Part1. Enter the disease, or comp	dar	M01442	4112 Old (Columbia P	ike Ellic	cott City,	y F.H.Inc. Md. 21043
ı	hysician /Medical		shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a. <u>Cardi</u>	ac Arre	est	g, 3431 43 34 41 40 31	To spiratory arrost,		Interval Between Onset and Death nknown
A) No	Examiner	ner	Sequentially list conditions, if any, sading to immisurate cause. Enter Underlying Cause (Disease or injury	b	tuntaquer.ce of):					
9/00,	cate be executed physician and the burial-transit	dical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (or as a od.	consequence of):					
	The law requires that the death certificate has been signed by the attending place 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive	ery Day Year
ras, r	quires that in signed by uld be deta	by	Part II. Other significant conditions co		not resulting in th	e underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to to	ne cause of death?
		Completed	Esophagitis					24a. Was an autopsy performed	prior to co	psy findings available mpletion of cause of
VII	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:	. #****	Oth	26. Place of Death			
lo no	ng Ph Iter th meral	ation: To	1 Yes 2X No 27. Manner of Death 1X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	28b. Tim	e of 28c. Injur	4 Nursing Hom	8d. Describe how i	e 6 □Other (Specifinjury occurred	y)
DIVISION		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home, farm (Specify)	, street, factory, office	2	8f. Location (Stree City or Town, S	t and Number or Rura fate)	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	(Check only 2 Medical Examone)	ysician: To the best of siner: On the basis of e and manner state	xamination and/c	r investigation, in my o	pinion, death occurre	d at the time, date	and place, and due to	the cause(s)
	To T Com	M	29b. Signature and title of certifier	a w		29c. Licens	44259		Date signed (Month, July 17, 2	•
)0	み			ter Reed AM	1C 6900	Georgia A	ve. NW Wa	shington	,D.C. 2030	7
ψŧ	Sta Registi		31. Date filed (Month, Day, Year) JUL 1 9 2	32. Sgistrar	s Signature	Could				

DHMH 17 Rev 1/2001

			1 - For State of Maryland /		artment of H			gienę Reg. No.	2006	24148
	*		Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		Howard O. Scharas				Ju1y	27,	2006	01:20A M
1	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of D	Death	4c. (County of Death	
		J.	Homewood Retirement Center		William If Under 1 Year	sport	Hee la Barrella		Washir	
- 4	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	Yrs.	Months Days		Min. (Month, Da	y, Year)		place (State or Foreign intry)
	Director		159-18-5002 87 Usual Residence of Decedent				02/28/	1919	Penr	sylvania
	yland		10a. State 10b. County 10c. City, Tov	wn or Lo	cation					10d. Inside City Limits
	Mar	ctor	Maryland Washington Willi	ams	port					1 ☐ Yes 2√∑ No
	or 28)ire	10e. Street and Number		10f. Zip Code			10g. Citiz	en of What Co	intry?
	ath w	ral	16635 Mosby Drive		21795				U.S.A.	
	er de	Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin In, Mexican, P	? (Specify Yes or No Puerto Rican, etc.))- 1	 Race - Amer Black, White 	
36	rs aft	by F	1 □ Never Married 2 13 Married 1 1 13 Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: WW 1 1		1 ☐ Yes 2 ☐ No	Specify:			Specify:	+ 0
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. ed other then "natural", or iteme 23a or 28e-f ehow event, the Miclical Examiner must be nutified at	ed	15. Decedent's Education 16a	a. Decer	dent's Usual Occup	ation		16b. Kin	whi d of Business/l	
215	hin 72	piet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	kind of work done of DO NOT use retired	du <i>ring</i> most of 1)	f working			
21	giene giene	Completed		les.	Represen	tative		Se1f	Employ	ed
D D	be filed hal Hygie od other	Be (17. Father's Name (First, Middle, Last)				Name (First, Middle			
yla V	should be and Menta marked maric ev	ဂ္	Alphonse Scharas				ouis I. Ur			
Maryland	2 sh and is m		1 1 21		-		iamsport,	-		ip Code)
	and Health In 27						Date		ation - City or 1	Town State
Baltimore,	T it it		1 23 Burial 2 Cremation 3 Memoral from State		sition (Name of natory or other place					
Ē	rtmer rtant		4 Donation 5 Other (Specify) Rest H		n Cemeter		/29/2006 Rest Haver			
Ba	permit. Pages 1 and 2 should by Opportunent of Health and Menta Important: If item 27 is marked any injury or other traumatic en 2006.		San P. File	16	601 Penns	ylvani	a Ave. Hag	gerst		21742
8.	Physician /Medical		23a. Pan . Enter the disease, or complications that caused the death. Do strock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pue to /or as a consequence.	1	full (M40047	<i>e</i> .		Approximate Interval Between Onset and Death
68760,4	Attending Physician: The law requires that the death certificate be executed refath. r death. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence c. Due to (or as a consequence d.		my Ang	794	Discage	5		Yerns
O. Box	res that the death certific signed by the attending p I be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deatt 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)	1		2	3d. Date of deli Month	very Day Year
Records, P.	w requires that been signed should be del	٥	Part II. Other significant conditions contributing to death but not resulting HAVIC ZOVE FACCARE	in the u	Handler of the state of the sta	en in Part I.	En - 10	Yes 2	No 3□Pro	
Rec	he law e has t	Completed	SENICE DONGWINA			 		ormed?	death?	opsy findings available ompletion of cause of
Vital	ifficati or, pa		25. Was case referred to medical			26 Place of	1 ☐ Yes Death (Check only of	2 No	1 □ Yes	2 No
	ysicis is cer direct	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/O	Outpatier	nt 3 DOA Oth	-	ng Home 5 ☐ Resi		☐Other (Spec	ify)
on o	ding Ph. h. After thi funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	. Time of	Wor		28d. Describe			
Division of		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, to building, etc. (Specify)	farm, str	eet, factory, office		28f. Location (. City or To		Number or Ru	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my moned 2 (Theck only one) 2 (The dical Examiner: On the basis of examination a and manner stated.	ja dasti ind/or in	h accurred at the tir vestigation, in my o	ne, fate and pinion, death	dece, and due to the occurred at the time,	date and	and manner 28 place, and due	stated to the cause(s)
	To the I within 2 To the I complet	Me	29b. Signatura/artitute of Sortifier		29c Licens	e number		29d. Date	signed (Manti	, Day, Year)
			MUCH MEDICAN)(10	To	~ ()(106)	7	127/20	26
	5		30. Name and address of Serson who completed cause of death (Item 23a)	(Type,	Prilate And	= H	TOCA TOCK	n). 1	111	2/747
<	Sta	ate	31. Date filed (Month, Day, Year) 32. In Istrar's Signature,	+14	Jario.	- 1/	10 41 11 ale	10	vi di	1116
	Registi		JUL 3 1 2006 Mesers D	A	pole					

			1 - For State Registrar	State of Maryla			nt of He te of D				Reg. No.	006	24149
	Physici	an	Decedent's Name (First, Middle, Las		Car	: h ::				Date of Di Month	Day	Year	3. Time of Death
	/Medic	al	Arlene 4a. Facility Name (If not institution, give	Guernsey	SC.	ibini		Location of De		<u> </u>	23	Zoolo County of Death	
1	Examin	er	Calvert Manor H			1	ising		Batti		40.	Ceci1	
AT S	Funeral		5. Social Security Number 6. Se		s. last birthday)	If Unde	r 1 Year	If Under 24 F	Irs. 8.	Date of Bi	rth ,	9. Birth	place (State or Foreign
	Director		022-05-5642	□M 2\XF 9	O Yrs.	Months	Days	Hours M	fin. Ji	ily 28	nth ay, 1915	Mass	achusetts
	yland		10a. State 10b. County	10c. C	City, Town or Lo	cation							10d. Inside City Limits
	a-1 st	tor	Maryland Cecil		E1kton							i	1 ☐ Yes 2 X No
	or 28	Dire	10e. Street and Number				Code					en of What Cou	
	a 23a	E I	26 Lake Forest Dri		110		1921					ted Sta	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itama 23a or 28a-f show amy injury or other traumatic event, the Maryland Exa. Litral mark is incilling at page.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give X		was Dece If Yes, spe 1 ☐ Yes		panic Origin? , Mexican, Pu Specify:	(Specify Jerto Ric	y Yes or N an, etc.)		4. Race - Ameri Black, White, Specify: Whi	etc.
9	hour tural	q pa	15. Decedent's Ed	Year or Dates:	16a. Dece			tion				d of Business/Ir	
5	in 72 n "na	Completed	(Specify only highest grad	de completed)	(Give	kind of wo	ork done du ise retired)	uring most of	working		TOD. KII	d of pasinessyll	ldustry
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ğ	al Hyg	Be C	17. Father's Name (First, Middle, Last)					18. Mother's N	Name (F	irst, Middle	, Maiden	Sumame)	
<u>a</u>	Menta Menta arked	To [John Stephen Gue	ernsey				Kath	nerin	ne Lo	uise	Hartney	
Maryland 21215-0036	nd 2 sho lith and 27 is mu r trauma	i	19a. Informant's Name/Relationship (7 Michael J. Scibi			-						Town, State, Zij	· ·
altimore,	s 1 au of Hea itam othe		20a. Method of Disposition	20b.	Place of Dispo	sition (Na	me of other place	,	Date		20c. Loc	ation - City or T	own, State
Ë	Page hert o int: If		1 🛱 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify						27,	2006	Cher	ry Hill, N	Maryland
Balti	permit. Departn Importe any inju		21. Signature of Funeral Service Licens	500	Ĥ	Name a	nd Address Home	for Fu	ınera	als,	P.A.	or a support on	
Tools.	40 = e d		Donaed.	S. Tulles	/ 11	J3 W.	Stoc	kton S	t.,	Elkt	on, M	D 2192.	
and a second	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	AIT		de of dying	, such as care	anac or re	sspiratory a			Approximate Interval Between Onset and Death
8/00, 1/2	te be executed ysician and e burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b									
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Hecords,	ysician: The law re is certificate has be director, page 2 sho	Completed							-	24a. Was auto perfe		24b. Were auto prior to co death? 1 \(\) Yes	opsy findings available impletion of cause of
/Ita	iclan: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					26. Place of D	Death (C	heck only	one)		
n of	ing Physician: After this certifica uneral director, p	lon: To	27. Manner of Death Natural 5 Pending	Hospital: 1 Inpatient 2 [28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work?	at			idence 6 how injury	Other (Special occurred	(y)
Division of Vital	al or Attending Phys a after death. I Director: After this	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factor		es 2 No	28f.		Street and wn. State)	Number or Rura	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edical	29a. Certifier Certifying Phyone) Certifying Phyone	rsician: To the best of my kr iner: On the basis of examir and manner stated.	nowledge, death nation and/or in-	n occurred vestigation	at the time	e, date and pla nion, death or	ace, and ccurred a	due to the	cause(s) a date and	and manner as s place, and due to	tated. o the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	_			c. License					signed (Month,	**
			Prof De	1			458	419			JULY	26,200	6
	20		30. Name and address of berson who of	DO 1881 TE	1 LZCVD31 2	1 Rox	00 R	LISING S	n 60.	N) 7	1911		
4	Sta	100.00	Of Data Stand Stands Day Your	2006 32. Redistrar's Sign	nature	hour	11		1		1),		
1	Registr	ar	2050 7	THE STATE OF THE S	1	No. of Street, or other Persons							

DHMH 17 Rev 1/2001

			1- For Amend item#28a-f, perVE, 0859,9/18/00 L	partment of Health and ertificate of Death	d Mental Hygier	ne Na2006	24150
L	Physici	an	Decedent's Name (First, Middle, Last) Dennis Neil Tinkelenberg		2. Date of Death July 14		3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De		4c. County of Death	11:20 A
	Examin	er	321 McMichaels Drive	Lusby		Calvert	
F .u.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours M	irs. 8. Date of Birth		lace (State or Foreign
	Director		218–56–8215 XIM 2 F 54 Yrs.		Jan 28 19	952 Mary	land
	how how		10a. State 10b. County 10c. City, Town or	Location		1	Od. Inside City Limits
	be filed within 72 hours after death with the Maryland lat Hyglene do other than "netural", or items 23a or 28a-f ehow event. I'n Medical Examinar must be notified at	Funeral Director	Maryland Calvert Lusby		100	Civir-re-résult-re-C	1 ☐ Yes 2 ☐ No
	with the a or 2	Dire	10e. Street and Number 321 McMichaels Drive	10f. Zip Code 20657		Citizen of What Coun	•
	death	era		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		14. Race - Americ	an Indian,
٥	or iter		Amed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2√ No Specify:	ieno Rican, etc.)	Specify: White,	
	ure!',	d by	3 Wildowed 4 Vivorced Year or Dates:		100	7711.	ite
21215-0036	in 72 n "net	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of v e. DO NOT use retired)	working). Kind of Business/Inc	dustry
212	filed with Hygiene. other thei	oml	Elementary/Secondary (0-12) College (1-4or 5+) 2 Cle	rical Supervisor		Banking	
	be filed tal Hygird d other event.	Be	17. Father's Name (First, Middle, Last)		Name (First, Middle, Maid	ten Sumame)	
Maryland		2	Chester J. Tinkelenberg	Julia ailing Address (Street and Number or	Dowell	tuor Tour State Zin	(Codo)
<u>8</u>	2 2 2 2			Napeleon Place,			Code
Je Je	of Health of Health fitem 27		20a. Method of Disposition 20b. Place of Disposition	sposition (Name of trematory or other placeJuly 15	Date 200	. Location - City or To	
altimore,				litan Funeral Ser		exandria V	irginia
Bait	permit. Pag Department Important: any injury c once.		21. Signature of Formal Service Licenge	22. Name and Address of Facility 405 Broomes I. Ro	Rausch, Funer	al.Home	
	00740		23a. Part1. Enter the disease, or complications that caused the death. Do not			blic MD 20	0676 Approximate
ė,	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions.	hyperthern	nia		Interval Between Onset and Death
8760,	cate be executed oblysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):				
.O. Box 6	that the death certificated by the attending phydelached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 8 \(\text{Unknown} \) Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	ery Day Year
rds, P	w requires that been signed t should be det	þ	Control of the significant conditions contributing to death but not resulting in	C		co use contribute to the	ne cause of death?
al Records,	The la ate has page 2	Completed		, ,	24a. Was an autopsy performed	prior to cor death?	psy findings available impletion of cause of
<u>=</u>	ysicien: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpa	Other	Death (Check only one) g Home 5 Residence	6 Other /Specifi	v1
1 0	ig Phy ter this	 		e of 28c. Injury at	28d. Describe how i	njury occurred	
Ö	ath. or: Aft	atlo	1 Naviral 5 Pending (Month, Day Year) Injuly 2 Describent investigation unk unk	M 1 ☐ Yes 2 X No		osed to high tal temperat	
Division of Vital	To the Hospitel or Attending Ph within Z4 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:		street, factory, office	28f. Location (Stree City or Town, S Lusby, MD	t and Number or Rura tate) 321 McMi	chael Drive
	Hospitei 24 hours Funerel (tely filled	edical	29a. Certifier 1☐ Certifying Physician: To the best of my knowledge, d (Check only one) 1☐ Certifying Physician: To the basis of examination and/o and manner stated.				
	To the Hospitel or within 24 hours after To the Funerel Dirt completely filled in I	Med	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
	->-0		Xan MI lible M	1 DI7324		7/17/06	
•	5		30. Name and address of person who completed cause of death (Item 23a) (Ty		N 0	1.0	
	0		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Huntingtown	WD 30	639	
18	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	B			

DHMH 17 Rev 1/2001

Patricia Marie Tana

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006-24151

			1- For State Regist⊧ar		Cei	rtificate o	f Death	7			F	Reg No	200	9	~ .	J 1
Р	hysicia		Decedent's Name (First, Midd	lle,Last)						2.	Date of Dea	ath	2.1	ĴŪ	3 Time of D	Death)
Medical			Patricia Mar	ie Tana							Month July 11, 2	Day 2006	Year		1145 h	rs
			4a. Facility Name (if not institution	on, give street and	number)		4b. City, To	own, or Lo	ocation of D				c County o	f Death		
			257 Congressional La	ane Apartment	218		Rockv	ille				1	Montgon	nery		
Fi	uneral		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Unde	r 1 Year	If Under 2	4Hrs.	8. Date of Bi	irth(MN	I/DD/YYYY	9. Birt	hplace (State	e or
	rector		214-52-6660			- 2	Months	Days	Hours	Min.	June			Foreig	⊓Washi	ngton
		-		1 M 2 XF		0.3 Yrs	5.		i		oune		1999	000	untry) DC	
	ž.	-	Usual Residence of Decedent 10a. State 10b. County		Inc. City	. Town or Locat	tion								10d Inside	City Limite
	w any		Tod. State		100. 011)	, 10111101 20001									1 X Yes	
and	28a-f show I at once.	5		gomery	Roc	ckville									X res	2 140
Aary	28a-	Director	10e. Street and Number				10f. Zip (Code			['	10g Cit	tizen of Wh	at Cour	ntry?	
hours after death with the Maryland	or items 23a or 28a-f sho must be notified at once.	ã	257 Congressi	onal Lane	e, Apt. 2	218		2085	2				USA			
with	1s 23a e noti	Funeral	11. Marital Status		ecedent Ever in U						ify Yesor No	0-	14. Race	Americ	can Indian, E	lack,
eath	iten ust I	립	1 X Never Married 2 N	lailleu	Forces?	If Y	es, specify	Cuban, I	Mexican, Pu	uerto Ri	can, etc.)		White	etc.		
ter d			3 Widowed 4 Di	vorced If Yes, Give		1	Yes 2	X No	specify.				SpecMyh	ite		
ırs af	Hygiene other than "natural" the Medical Examine	<u>a</u>	15. Decedent's Education (Spe	or Dates:		16a. Deceder				d of wor	k done	16b.	Kind of Bus		ndustry	
2 hou	"naf	ompleted	Elementary/Secondary (0-12)		(1-4 or 5+)				O NOT use						,	
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0036 within	Hygiene t other t the Me	팅	17. Father's Name (First, Middle			Macte	ar ne				irst, Middle,		Sareg	uaro	d Anal	yst
21215-0036 uld be filed within 7	d of	ပ၂	11. I ather a Name (I hat, Micore	s, Last)					. Woulder 5 IV	allic (I	iist, wildate,	Maidei	r Surname)			
12 d be	Mental F marked c event,	Be	Joseph J. Tan 19a. Informant's Name/Relation	a		4.01- 14-11-	- A -l -l	A ₁	nna Ca	<u>athe</u>	rine	Fel	der			
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e, MD I and 2 sho	Ith a n 27		Eileen T. Dunn	ington/											r, FL	33572
- F	nent of Health and N tant: If item 27 is n or other traumatic		20a. Method of Disposition	n 2 Domaus		Place of Dispos crematory or ot		e of ceme			Date		Location -	City or	Town, State	
<u>5</u>	oth C		1 Burial 2 Crematio		I IIOIII State	e of Hea		meter	,	July	19,	۱.,		~		_
Baltimore,	rtme ortar y or	ł	4 Donation 5 Other S 21. Signature of Fungral Service							200		Sı	Iver	Spr.	inq, M	arylar
Z B E	Department of H Important: If i injury or other	Í	1 1	0.		Fra	ancis	J. (Collin	ns E	unera	1 H	ome I	nc:		00001
- 8			23a Part I. Enter the disease, o	complications tha	t caused the death										g, MD	
	sician edical		failure. List only one cause		t caused the death	i. Do not enter t	rie illoue oi	r aying, so	icii as cardi	iac oi re	aspiratory an	1631, 311	ock, or riea		Between	Onset and
	miner		Immediate Cause (Final disease		sive Atherosc		iovascul	ar Dise	ase						De	ath
			or condition resulting in death)	, Due to (or a	s a consequence o	of):										
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		ne	if any, leading to immediate cause. Enter Underlying Cause		s a consequence o	of):										
	130	Examiner	(Disease or injury that initiated	C	s a consequence o	of):			_	_				_	-	
pet	nsit	ŭ	events resulting in death) Last	d	o a concequence a	,,,,										
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, pe e	ng physician as the burial	n/Medical	UNPENDED	AMENDE							_					
8760, tificate bo	phy:	Ž	IF FEMALE: 23b. Was decedent pregnant in t	iho -	s, outcome of preg							23	d Date of o			
68 ertif	iding se as	la	past 12 months?	I LIV	e birth gnant at time of de	2 Fe		_	Ectopic pre	egnanc	у	U	Month	D	ay	Year
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رة بر	hed f	چ		9 011	known		4 1 2				Too- D:-			1-1-1		111-0
P.O.	ned by the attending detached for use as		Part II. Other significant condi	tions contributing	g to death but not r	esulting in the i	underlying	cause giv	en in Part I.					_	he cause of	
res t	signed l	Completed by	Liver Cirrhosis							_	1 Ye	s 2	No 3 €	Prob	ably 4 l	Jnknown
Division of Vital Records,	been s	ete									24a. Was				opsy finding	
S	has e 2 sl	ם								_	perfo	rmed?		eath?	ompletion of	cause of
Re ≟	ricate page	اق									1 Yes	21	No 1	√ Ye	s 2	No
<u>19</u> 19	certif	Be	25. Was case referred to medic examiner?					-	f Death (Ch		, ,					
by Sic	this	0	1 ✓ Yes 2 No	Hospital 1	Inpatient 2	ER/Outpatient	3 DC	DA U	ther ₄ N	ursing H	Home 5	Reside	ence 6 🗸	Other:	Scene	
્રે ૦	After t funeral	اڃَا	27. Manner of Death	28a. Da	ite of Injury nth, Day,Year)	28b. Time of	Injury 2	8c. Injury	at Work?	28	d. Describe	how inj	ury occurre	d		
endi:	ath he fu	Ęį		nding	, ,			1 Ye	s 2 No	,						
Si	er death rector: 1 by the	Certification:		estigation 28e. P	ace of Injury - At h	ome, farm, stre	et, factory,	office bui	lding, etc.	28	If Location (Street a	and Number	r or Rur	al Route Nur	mber, City
ž į	ours afte	Έ	dete	uld not be Speci	fv)						or Town, S	State)				
Spit	hour mera y fill		4 Homicide 29a. Certifier		-					1						
e H	n 24 le Fu	g	(Check only Certifying r	Physician: To the laminer:On the bas												
To th	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical		and manne	r_stated.	androi ilivestiga				cu di ii	– unie, date					
ţ.	7 - 0	ž	29b. Signature and title of certif	ier			29c.	License	number			29d.	Date signe	d (Mon	th, Day, Year)
1	ν		Qual?	*				O.C.M	.E.			July	y 12, 200	6		
-	-		30. Name and address of perso	n who completed a	ause of death /Ito-	n 23a)										
				n wno completed c sist ant Medic a		· ·	Street R	altimor	MD 21	201						
				- 100	Régistrar's Signati		street, b	animi Oli	J, WID Z I	201						
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			1 - For State Registrar	State of I	Marylar	•	artment of rtificate o			lental Hygi	ene g. No. 2	006	241	52
	Physici	an	Decedent's Name (First, Middle, La		_	_			i	2. Date of Death Month	Day	Year	3. Time of Dea	th
	/Media		Aglaia	TSer		S				JUIY!	1	2006	0801	/ M
>	Examir	er	4a. Facility Name (If not institution, give				4b. City, Town					ity of Death		
			SHADY GROVE ADVENT 5. Social Security Number 6.3			last birthday)	If Under 1 Yea	OCKVILL It Under		8. Date of Birth	MON	TGOMER	lace (State or For	roign
	Funeral Director		,	1 □ M 2 🗓 F	94	Yrs.	Months Day		Min.	(Month, Day, FEBRUARY		Cou	GREECE	eign
	ם.		Usual Residence of Decedent				I			1 IIII III I	20,1712		GREECE	
	how how	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	ecation					1	0d. Inside City Lin	
	8a-f	cto	MARYLAND MONTGOMER	Υ			GAITHER	SBURG					1 □ Yes 2 🔯	J NO
	with th	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen o	f What Cour	ntry?	
	e 23e	by Funeral	333 RUSSELL AVENUE,	APT. 316	nt Funcin II	6 12	Was Doordoot s	20877		adı Van as Na		S.A.	on Indian	
40	iter d	Ë	11. Marital Status 1 □ Never Married 2 □ Married	Amed Force	s?	.3.	Was Decedent of If Yes, specify Co	iban, Mexica	n, Puerto	Rican, etc.)		ack, White,		
980	urs af	þ	3 ⊠ Widowed 4 □ Divorced	If Yes, Give Year or Date			1∐Yes 2⊠N	o Specify:	:		Spec	ify: WH	ITE	
Maryland 21215-0036	within 72 hours after death with the Marylend ene. than "natural", or iteme 23e or 28e-f ehow he Medical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gr				dent's Usual Occ kind of work dor		et of worki	1	6b. Kind of	Business/In	dustry	
2	ithin 1	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use reti	red)	SI OI WOIKI	ng				
2	led w lygier her th	ပိ	5				HOMEMAKE					N HOME		
and But	be fi	Be	17. Father's Name (First, Middle, Last							(First, Middle, M	laiden Suma	ame) UKN		
Ž	d Mei d Mei mark matic	ပ္	CONSTANTINE PAPANIO			10h Mailie	Address /Stre		MAGDAI	ENE Number,	City or Tow	o Ctato Zio	Cadal	
Σ	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or iteme 23a or 28a-f ehow mortant: in the 23a or 28a-f ehow injury or other traumatic event, the Madical Examinat must be notified at once.		C.H. TSERONIS - SOI								•	11, 3(a)6, 21p	C00e)	
ā,	I Hear		20a. Method of Disposition	<u> </u>	20b. F	Place of Dispo	sition (Name of			MARYLANI	Oc. Location	n - City or To	wn, State	
Baltimore,	Page ento nt: if		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		ite		natory`or other p CAVEN CEME		וווע 1	5, 2006	TI WED	CDDINC	MADSH AND	
alti	mit.		21. Signature of Funeral Service Lice		GA		2. Name and Add			NES-RINALI				
m	8218		Messlent. Wol	et		11	.800 NEW H	AMPSHIR		WE, SILVER				٠
J.	Physician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Pul	ine. V\O\\ as a conseq	equence of):	den a				st,		Approximate Interval Between Onset and Death 2. Low	h
8760,	The law requires that the death certificate be executed are has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai Examiner	E equentially list sunditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a conseq	uence of):	larked	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	ren.	>- <u></u>			lday	
P.O. Box 6	that the death certifice ed by the attending pt detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 □ Feta tat time of d	Ideath 3□	Ectopic pregnar Other (specify)				1	ate ot delive	ny Day Year	
C,	res that igned b be deta	by PI	Part II. Other significant conditions		۸	-	nderlying cause o	given in Part I	l.	23e. Did toba	acco use co	ntribute to th	e cause of death	?
ğ	w require been sig should b	edt	Drabete K	ctoacia	40117					1 ☐ Yes	2 2 √ No	3 ☐ Prob	ably 4 □Unkno	nwc
900	e law re has be je 2 sho	Completed	Sepsis							24a. Was an autopsy		. Were auto	psy findings availa	able
Ě	The ate his page	mo;								perform		death?	npletion of cause 2₽No	OI .
<u>it</u> a	ortific octor,	Be (25. Was case referred to medical examiner?					26. Place	e of Death	Check only one				
Ž	hysio this co	ို	1 Yes 2 No	Hospital: 1 ₽1npa		ER/Outpatien	3 DOA		ursing Hor	ne 5 ☐ Resider	nce 6 🗆 O	ther (Specif	1)	
Ĕ	ing P	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending		njury Day Ye <i>ar)</i>	28b. Time of Injury	W			28d. Describe hov	v injury occu	urred		
	or Attanding Physician: after death. Diractor: After this certifice in by the funeral director, i	Certification:	2 Accident investigatio 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of	Injury - At he		M 1	⊒Yes 2□ e		28t. Location (Stre City or Town,		nber or Rura	l Route Number,	
Ω	Hospitel 4 hours Funeral ely filled	edical Ce	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa	hysician: To the be miner: On the basis and manner	s of examina	wledge, death	n occurred at the vestigation, in my	time, date ar	nd place, a	and due to the car ed at the time, da	use(s) and n	nanner as si	ated. the cause(s)	
	To the within 2.	Mec	29b. Signature and title of certifier	and manner	Juliou.		29c. Lice	nse number		29	d. Date sign	ed (Month.	Day, Year)	
			1 dusctr	MO			00	200	79	54 0	JULY	09	, 2006	5
	3		30. Name and address of person who	1 1	of death (Item	n 23a) (Type,	Print)	US F) l K	E No	Choul	J. J. M	5082	2
	Sta		31. Date filed (Month, Day, Year)		strar's Signa		Als .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per / th 2858 8-1106 State of Maryland / Department of Healt Mand Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 20 JOAN ELEANOR TAYLOR 2006 12:10 July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ceci1 E1kton Union Hospital If Under 1 Year Months Days Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7/10/1937 213-36-6151 1 M 2 XF 69 Months Hours Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f ehow d other than "netural", or iteme 23a or 28e-f ehovevent, Ite Medical Examinations to notified at Director 1 ☐ Yes 🏋 ☐ No Aberdeen Harford MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with toent of Heatth and Mental Hygiene. Int: If Item 27 Ie marked other then "netural", or Iteme 23a or 2 USA 21001 330 Graceford Drive Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No White þ If Yes, Give Year or Dates Specify 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Florian Evernia Frantum Harold Jerome Taylor 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21001 330 Graceford Drive, Aberdeen, MD Deborah J. Pollard/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
eny injury or ot
ance. 1 X Buriat 2 ☐ Cremation 3 ☐ Removal from State Havre de Grace, MD 7/24/2006 Rock Run Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 17314 Harkins Funeral Home, Inc., Delta, PA Part 1. Effer the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Shock **Physician** Septic disease or condition resulting in death) /Medical Due to (or as a consequence of): disease on dialysis Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and the for use as the burial-transit The law requires thet the death certificate be executed menic Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ፭ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 has autopsy performed? certificate 1 Yes 2 0 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No 1 Donpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: this After death. Director: filled in by hours after hin 24 hours a

within

2

DHMH 17 Rev 1/2001

State Registrar

Medical

1 Matural

2 Accident

3 Suicide

29a. Certifier

29b. Signature

4 Homicide

(Check only one)

(same 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending

investigation

6 Could not be determined

118 Street Ste 3B Elkhon M 2/92/, NOSTL 32. Registrar's Signature

Injun

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes

Tercertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

2 No

00063720

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

		•	For Stete Registrer		State of	Marylan		artmen rtificate			nd Men		giene Reg. No.	200	6	24154
		Sh.		e (First, Middle, La	st)							Date of De		Yej	ar	3. Time of Death
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	Funeral Director		5. Social Security N	-7136	ex XM 2□F	7. Age (In yrs. I 56	last birthday) Yrs.	If Under Months	Days	Hours	Min. 8. (Date of Bir Month, Da Ppt. 2	26, 19	9. 949 M	Countr	ce (State or Foreign 71and
	land ow		Usual Residence o 10a. State	10b. County		10c. City	y, Town or Lo	cation							100	d. Inside City Limits
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036	ē = =	by Funeral	11. Marital Status 1 □ Never Mari 3 □ Widowed	ried 2 <mark>X</mark> Married 4 □ Divorced	12. Was Dece Armed For 1 Tes If Yes, Give Year or Da	dent Ever in U. ces? 2 M No e ites:	1	Was Deced If Yes, spec		spanic Origir n, Mexican, f Specify:	n? (Specify Puerto Rica	Yes or No in, etc.)		4. Race - A Black, W Specify:		c.
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<u>a</u>	id be ental ked o	To Be		d Trainc						Marg	garet	Bro	own			
ary	12 should be filed within h and Mental Hygiene. 7 is marked other then " traumatic event, the Men	-	19a. Informant's N	lame/Relationship (Type, Print)			-		nd Number			-			
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ainor a	w requires tha been signed should be del	ed by P	Part II. Other signi	ECTEN	S/00	eath but not resi	ulting in the u	inderlying c	ause give	n in Part I. ACTER	4		obacco u Yes 2	_	e to the	cause of death?
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Vita	Physician: r this certific ral director,	Be	25. Was case refe examiner?	/	Hospital:		/		Othe	26. Place o						
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	/O	nta-	30. Name and add	oress of person who	ANT	e of death (Iten	RIV	Print)	de	DI	A(02	50	ELSE	My 1	4021201
	Regist	rar		JUL 3 4	006	lalva.	D A								/	
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			For State Registrar		State	of Marylar	•	artmen <i>rtificat</i>				ental H	ygien Reg. N	$-2 \mathrm{H}$	16	24	155
			1. Decedent's Name (First, Midd	le, Last)								2. Date of I Month		ay \	/ear	3. Time o	f Death
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	Examir		4a. Facility Name (If not institution	on, give s	treet and no	ımber)		4b. City,	Town, or	Location	of Death		4	c. County o	Death		
			2100 Plyers M	+						Sprin						omery	
	Funeral		5. Social Security Number	6. Sex	M 212 F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	Min.		Day, Yea	r)	Cour		•
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	and and		Usual Residence of Decedent 10a. State 10b. Count	у		10c. C	ity, Town or Lo	cation			-				1	0d. Inside C	ity Limits
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ita	sician: Th certificete rector, pag	Be (25. Was case referred to medic examiner?	al								(Check onl					
<u>></u>	Physician: this certific ral director,	2	1√ Yes 2 No	Н	ospital: 1 [Inpatient 2	ER/Outpatien	it 3□ DC	Oth Oth	er: 4□Ni	ursing Hor	ne 5 🙀 Re	sidence	6 □Other	(Specify	1)	
u	ding P h. After t funera	i.	27. Manner of Death 1x□Natural 5 □ Pend	ina	28a. Date (Mo	of Injury nth, Day Year)	28b. Time of Injury		8c. Injun Worl	k?		28d. Describ	e how in	ury occurred	1		
sio	e at a	cati		tigation				М		Yes 2□	-						
Division	i or Atten after deat Director: in by the	Certification:		mined	28e. Ptad	e of Injury - At hiding, etc. (Spec	nome, farm, str ify)	eet, factory	, office		1	28f. Location City or 1	(Street a Town, Sta		or Rura	l Route Num	ıber,
_	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th		29a. Certifier 1 🔀 Certify	ing Phys	ician: To th	e best of my kn	owledge, deatl	n occurred	at the tin	ne, date ar	nd place, a	and due to th	ne cause(s) and man	ner as si	ated.	
	ne Ho	edicai			er: On the	basis of examin nner stated.											s)
	To the within 2. To the complet	Me	29b. Signature and title of certifi	er	.0			290	c. Licens	e number			29d. D	ate signed	Month,	Day, Year)	
	6			معود	M	u	2		D31	891			Jι	11y 14	, 20	006	
-	•		30. Name and address of person Amit Rajvansh		mpteted cau	use of death (Ite 21 Cong	m 23a) (Type, ressio	Print) nal L	ane,	#409	9, Ro	ckvil:	le, I	MD 208	52		
	Sta Regist	ate rar	31. Date filed (Month, Day, Yea.		32.	Registrar's Sign	ature	arte	,	······							

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State of Maryland / Department of Health and Mental Hygiene

2006 24156

George Roland Wolfe, Jr. 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 1418 hrs Medical Examiner WOLFE JR. July 9, 2006 GEORGE ROLAND 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Hagerstown Washington 112 Summer Street If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Director CouMaryland 212-78-2579 196 1X M 2 F 39 March 14 Usual Residence of Decedent 10c City, Town or Location 10d. Inside City Limits any 1 X Yes 2 No 28a-f shov Maryland notified at once. Washington Hagerstown Director 10g Citizen of What Country 10e. Street and Number 10f. Zip Code U.S.A. 112 Summer Street 21740 Funeral 13 Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status Was Decedent Ever in U.S. items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 Never Married 2 Married Yes 2 X No White Widowed 4 X Divorced If Yes, Give Year Yes 2 X No specify. Specify: Examiner ⋧ 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than "injury or other traumatic event, the Medical Injury or other traumatic event, the Medical MD 21215-0036 Mason Construction 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wolfe George Roland $\operatorname{\mathtt{Sr}}$ Edith Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 232 1/2 North Potomac Street, hagerstown,Md. 21740 Edith M. Brown Mother 20b. Place of Disposition (Name of cemetery, Date 20c Location - City or Town, State 20a Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cedar Lawn Memorial Pk. 07-13-06 Hagerstown, Maryland 4 Donation 5 Other Specify 22. Name and Address of Facility
Andrew K. Coffman Funeral Home, Inc.
40 East Antietam Street, Hagerstown, 21. Signature of Funeral Service Licensee rock Md. 21740 23a Part I Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest **Physician** Between Onset and failure. List only one cause on each line /Medical Death Hypertensive Cardiovascular Disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) iner cause. Enter Unidentifying Cause (Disease or injury that initiated Exam Due to (or as a consequence of) events resulting in death) Last and sician/Medical AMENDED 23a,27 per meo g858 8-16-06 vt **X** UNPENDED physician the burial Box 68760, 23d Date of delivery IF FEMALE 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Dav Year past 12 months? 2 Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I ⋧ 1 Yes 2 No 3 Probably 4 V Unknown Chronic alcoholism Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes 2 No 26 Place of Death (Check only one Hospital or Attending Physician: 25. Was case referred to medical Be Other₄ examiner? DOA Nursina Home 5 Residence 6 V Other: Scene Inpatient 2 FR/Outpatient 3 After this 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d Describe how injury occurred 1 X Natural 1 Yes 2 No 5 Pending Director: 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Will Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 and manner stated 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) July 10, 2006 O.C.M.E. 30. Name and address of person who completed cause of de ath (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year), 32. Ragistrar's Signature State 2006

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Registra

Physicia /Medic					Cei	tificate	e of L	Death			Reg. No.	UUb	Z 4 1	Drait
/Medic	_	Decedent's Name (First, Middle, Last) WILLIAM WYNN WRIG	HT							2. Date of Dea Month JULY 15,	Day	Year	3. Time of 4:25	777
Examine		4a. Facility Name (If not institution, give s		or)		4b. City,	Town, or	Location o	of Death			unty of Deat		
		1301 DILSTON PLACE						SPRING				ONTGOME		
Funeral Director		5. Social Security Number 6. Sex 1 🔀	M 2 F	Age (In yrs. Ia 82	st birthday) Yrs.	If Under Months	Days	If Under: Hours	Min,	8. Date of Birt (Month, Da 8/13/19	y, Year)	9. Birt Cc MARY	hplace (State of buntry) LAND	r Fore
> 50	F	Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation							10d. Inside Cit	tv Lin
• ho	5	MARYLAND MONTGOMERY	1		LVER SP								1 🗆 Yes	
28a-	Director	10e. Street and Number				10f. Zip	Code		-		10g. Citizen	of What Co	ountry?	
3a or	D	1301 DILSTON PLACE					20903				US	SA		
Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23s or 28s-f ehow eny injury or other treumatic event. Ite Medical Examinar must be notified at once.	by Funerai	1 Never Married 2 Marned	2. Was Deceder Armed Force 1 Yes 2 I If Yes, Give	s? XNo		Was Deced f Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specify:		ecify Yes or No Rican, etc.)		Race - Ame Black, Whit ecity: WH		
tural' al Ex	d ba	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates	s: 	16a. Dece	dent's Usua	al Occupa	ation				of Business		
deals	Completed	(Specify only highest grade	completed)	v. 5 . \	(Give	kind of wo. DO NOT us	rk done o	lurina mos:	t of worki	ing	, , , , , , , , , , , , , , , , , , , ,		,	
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othe vent.	Bec	17. Father's Name (First, Middle, Last)								(First, Middle,		mame)		
Menta arked	10	ANDREW WYNN WRIGHT								T MARY PE				
is m		19a. Informant's Name/Relationship (Ty)								Al Route Number			Zip Code)	
Health Im 27 Her tu		THERESA WRIGHT - WIF	E	20h PI	ace of Dispo	DILSTO		JE; S.		SPRING M			Town, State	
ant: if its		1 ☑Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta	te ce	emetery, crei E OF HE	natory or o	ther place		7/19/		SILVER			
Departn imports eny inju		21. Signature of Funeral Service License Myelin	Wlobe	1					-	ES-RINALD ; SILVER				
ysician and wisicien and whisicien and strength the privat-transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	STATIC I as a consequ as a consequ as a consequ	rence of):	CANCI	EK .							
by the ettending p	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcor 1⊟Live birth 4⊟Pregnant 9⊟Unknow	at time of de	death 3[∃Ectopic pi ∃ Other (sp				- 17	23d	. Date of de Month		Year
signed d be de	ρ	Part II. Other significent conditions cor END STAGE RENAL DI		h but not resu	ulting in the u	nderlying o	cause give	en in Part I	l.		obacco use Yes 2 🔀 N		o the cause of d robably 4 🗆	
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ofter thu		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of I (Month,		28b. Time o Injury		28c. Injun Worl			28d. Describe			ony,	
4 hours after death. Funerel Director: Afte tely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of building,	Injury - At ho , etc. (Specify	me, farm, st	reet, factor	y, office			28f. Location (City or To		lumber or R	ural Route Num	ber,
within 24 hours al To the Funerei D completely filled i	Medicai (29a. Certifier 1 Certifying Physical Check only 2 Medical Exami		s of examinat										;)
within 2 To the complet	Me	29b. Signature and title of certified	10		_	29		e number			29d. Date s	igned (Mon	th, Day, Year)	
≤ → ○		l W	W419 W		MD		D 3	339	117	_	ודה	1712	ME	

State of Maryland / Department of Health and Mental Hygiene 0 6 24 | 58 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Charles Edward Wood, Jr. Juliv 12, **Physician** 2006 1:30P. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard 9353 Ourtime Lane Columbia 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept. 25, 1950 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days Hours 1**X** M 2□ F 55 Washington, D.C. 212-54-0021 Yrs. Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location r then "neturel", or items 23a or 28e-f ehow the Medical Exerciper must be notified at Columbia 1 Yes 2 No Maryland Howard Directo 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21045 United States 9353 Ourtime Lane 12. Was Decedent Ever in U.S. Amped Forces? 1 □ Wes 2 □ No If Yes, Give Year or Dates:1968-1970 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Depertment of Heelth and Mental Hygiene. Importent: If tiem 27 is marked other then "neture!; or then any injury or other traumatic event, the Medical Examination. 1 Never Married 2 Married White 1 □ Yes 2 No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done do life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Firefighter Prince George's County 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charles Edward Wood, Sr. Barbara R. Greene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deborah H. Wood -wife 9353 Ourtime Lane Columbia, Maryland 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1∆ Burial 2 □ Cremation 3 □ Removal from State George Washington Cemetery 7/17/2006 Adelphi, Maryland 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee Dönald V. Borgwardt Funeral Home, PA <u>4400 Powder Mill Road Beltsville, Maryland 20705</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 2 Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung Cancer Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hoepitel or Attending Physician: The law requires that the death certificate be executed signed by the attending physicien and d be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 No 3 Probably 4 Unknown cete hes been sig , page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No this certificete 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident illed in by the Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 17.1 July 13, 2006 354562 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael Gibson, M.D. Johns Hopkins Hospital 401 N. Broadway Weinberg Bldg.,#1400 Baltimore, Manyland21231 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 14 2006 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Rosalie Bertha Braun 1- For State Certificate of Death Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ Month 1235 hrs Medical Examiner July 30, 2006 Rosalie Bertha Braun 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore City** 3161 Stafford Street N/A Date of Birth (MM/DD/YYY 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs last birthday) Funeral Foreian Days Hours Country) MD 03/30/1936 Director 220-34-5477 1 M 2 X F 70 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location î 10a. State 10b. County 1 X Yes 2 No 28a-f show N/A Baltimore City irector 10g. Citizen of What Country 10e. Street and Number "natural", or items 23a or 28a-I Paminer must <u>be notified at</u> 3161 Stafford Street 21223 United States 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 X No White Specify. 1 Yes 2 x No specify. Yes, Give Yea 3 Widowed 4 X Divorced þ 16a, Decedent's Usual Occupation (Give kind of work done 6b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed I and 2 should be filed within 72 he Health and Mental Hygiene fitem 27 is marked other than "n er traumatic event, the Medical E Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Retail Sales Clerk N/A18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Braun Mildred Minnie Imbragulio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 19a. Informant's Name/Relationship (Type, Print) ဥ 4611 Kramme Ave., Baltimore, Charles Blank (Son) Maryland 21225 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) it: If it 1 Burial 2 Cremation 3 Removal from State permit Page Department of Important: New Cathedral 08/04/2006 Baltimore, Maryland Donation 5 Other Specify 22. Name and Address of Facility 2 Sig ture of Funeral Service Licensee, Hubbard Funeral Home, Inc. and 21229 14107 Wilkens Avenue, Baltimore, Ma 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart Mary Approximate Interval Physician Between Onset and failure. List only one cause on each line Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical UNPENDED **AMENDED** attending physician or use as the burial certificate be Box 68760. 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Day Month 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, P.O. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an peen autopsy prior to completion of cause of death? performed Yes 2 V No page

certificate has this Division Director:

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Certification:

Medical

To the Funeral

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3

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Accident

26 Place of Death (Check only one) 25. Was case referred to medical Other₄ Hospital: 1 Nursing Home 5 Residence 6 🗸 Other Scene R/Outpatient 3 Inpatient 2 1 🗸 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 V Natural 1 Yes 2 No 5 Pending

28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie July 31, 2006 OCME

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner

32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 U U 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 28, ^{Day} 2006 **Physician** Roxanne Marie Bowers 4:00 A^{M} /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Towson Baltimore Gilchrist Center For Hospice | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ ▼ Yrs. 44 2,1962 Maryland Director 212-88-8206 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 ☐ No Maryland | Baltimore Nottingham Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code the Medical Examiner must be 7 Fallon Court, Apartment "B" 21236 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 12 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 Yes 202No Specify. Completed by White 3 Widowed 4 Divorced "naturs!" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) 12 than College (1-4or 5+) Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I int: if item 27 is marked o Ethel Mae Wieneke 2 Theodore Woodrow Bowers, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1715 Good View Road, Baltimore, Maryland 21234 Theodore Bowers, Jr. (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 31,2006 Baltimore, Maryland Baltimore Cemetery 21. Signature of Funeral Space Liceopte 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. Old Fastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death DEEKS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Exami and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 VINO 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 1 Watural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after c determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 02

2006

GLODI N.

06-05553 Minnie Bethea

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 21161

	F	1- For State Registrar	Certificate of	Death			g. No.	0 4410
Physicia ledical Examin	n/	1. Decedent's Name (First, Middle,Last) Minnie	Bethea			2. Date of Death Month July 29, 20		3. Time of Death 1945 hrs
		4a. Facility Name (if not institution, give street and number) 206 North Spring Court		4b. City, Town, or Baltimore	Location of Deatl	1	4c. County of Death	
Funeral Director		250-18-4886 1_M 2XF	n yrs. last birthday) 90 Yrs	If Under 1 Yea Months Day		→	-1916 9. 8iri -1916 Co	
d low any		Usual Residence of Decedent 10a. State 10b. County 10 Md . NA	c. City, Town or Local		···-			10d Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 206 N. Spring Ct.		10f. Zip Code 2123]		10	g. Citizen of What Coul USA	ntry?
leath w	L	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2	_ If Y	as Decedent of His es, specify Cubar	n, Mexican, Puerto		White, etc.	can Indian, 8lack,
nore, MD 21215-0036 ges, I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene it: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner	ক্র	Widowed 4 Divorced of Pates: 15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)	during n	Yes 2 X No nt's Usual Occupa nost of working life	tion (Give kind of		Specify B1 16b. Kind of 8usiness/	ack Industry
21215-0036 Juid be filed within 7. Mental Hygiene marked other than ic event, the Medical	Completed	9th grade 17. Father's Name (First, Middle, Last)	Labo	rer	18.Mother's Nam	e (First, Middle, M		
1215 d be fill ental H arked	Be	Joseph 19a. Informant's Name/Relationship (Type, Print)	Jones Link Moilie	a Addrona (Cha	Mary	Burel Boute Numb	Campk ber, City or Town, State	
- p = E =		Patricia Brooks Niece 20a. Method of Disposition					altimore, 1 20c. Location - City or	
Baltimore, sermit Pages I ar Department of Hes important: If itel injury or other tr		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	crematory or or St. Mary	her place) 's Cem.	8-	5-06	Dillon. S	.C.
		21. Signature of Funeral Service Licensee 4 Lady Ware	M	Name and Addres	. East	1101 E	imore, Md. . North Ave	21202
Physician /Medical Examiner		23a. Part I. Enter the diseas. or complications that caused the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)		ine mode of dying	, such as cardiac	or respiratory arre	st, snock, or near	Between Onset and Death
	ler	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence)						
by a ig	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence)	uence of):					
760, cate be executed physician and the burial - transi	edical	d. UNPENDED AMENDED						
	ΣI	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 F	etal death 3 ther (Specify)	Ectopic pregr	nancy	23d. Date of deliver Month	y Day Year
, P.O. Beires that the designed by the	ğ	Part II. Other significant conditions contributing to death b	out not resulting in the	underlying cause	given in Part I.		bacco use contribute to	
cords, law requir has been s	Completed					24a. Was a autops perfor	sy prior to med? death?	utopsy findings available completion of cause of es 2 No
ital Reician: The scerificate	BeC	25. Was case referred to medical examiner? Hospital: 1 Inputient			other Nurs		Residence 6 🗸 Othe	r Soons
ing Physi After this funeral dir	ပ	1 ✓ Yes 2 No Impatient 27. Manner of Death 28a. Date of Injury	28b. Time of		ury at Work?		ow injury occurred	r. Scerie
ion (tending eath.	ation	1 V Natural 5 Pending 2 Accident Investigation	ir)	1	Yes 2 No			
Division ospital or Attenchours after death	Certification:	3 Suicide 6 Could not be determined (Specify)	ry - At home, farm, str	eet, factory, office	building, etc.	28f. Location (S or Town, S		ural Route Number, City
To the Host within 24 ho To the Func	Medical C	29a. Certifier 1 Certifying Physician: To the best of my lone) 2 Medical Examiner: On the basis of examinar and manner stated.	knowledge, death occ ination and/or investig	ation, in my opinic	n, death occurred	nd due to the cause at the time, date a	and place, and due to the	ne cause(s)
F 3 F 3	Me	29b. Signature and title of certifier Mhysa Brassell V	18		.M.E.		29d. Date signed (Mo	onth, Day, Year)
5		30. Name and address of person who completed cause of dea Melissa Brassell, MD Assistant Medical B		Penn Street,	Baltimore, M l	21201		
S Regis	tate trar	ALIG U. 2 71116 Mario	s Signature	and I				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:30 P.M IA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CHRIST 110 9. Birthplace (State or Foreign Country)

MARVL ANL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Months -62-2448 1**⊠**M 2□ F Yrs. Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "naturel", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Director MARYLAND 10g. Cit/zen of What Country? 10e. Street and Number 10f. Zip Code WARWICK by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) other then College (1-4or 5+) MORTON permit, Pages 1 and 2 should be filed v Department of Health and Mental Hygier Important: If Item 27 is marked other It any injury or other traumatic event, ILA 2002. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be 15TON ၉ WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number for Rural Route Number, City or Town, State, Zip Code) SON 010 WARWICK AVE. HNTHON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2/□Cremation 3 □Removal from State UWINGS MI 4 Donation 5 Other (Specify) SON 21. Signature p Funer | Service License 22. Name and Address of Facility Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer YEGVS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, 1 y 1 second 1 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the attending physicien and l or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 △No 24a. Was an autopsy performed? this certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Nos Pro-1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Funeral Director: A Hospital completely To the

State Registrar

29b. Signature and title of certifie

T, Suite 209, 65 31. Date filed (Month Pay,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 00061199 29d. Date signed (Month, Day, Year)

July 30, 2006

Touson hid

			For State Registrar	State of Marylar			nt of H Ite of L		nd Mer		ene g. No.	.006	24/63
	Physicia	an	1. Decedent's Name (First, Middle, Last) EUGENE		RO	TEL	-Λ			Date of Death Month	Day	Year	3. Time of Death
>	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)	170			Location of (217	-	Ounty of Death	, , , , , , , , , , , , , , , , , , , ,
			Bon Secours Hospi				ltimo:		Use L		N/		
	Funeral Director		5. Social Security Number 6. Sex 1 🕱	M 2□F 7. Age (In yrs. 76	last birthda	Month	er 1 Year s Days	Hours	Min.	Date of Birth (Month, Day, 1) 0ril 22	Year)	Cos	place (State or Foreign intry) yland
	land	-	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or	Location							10d. Inside City Limits
	Mary He sh	tor	Maryland Anne Arun	del G1	en Bur	nie							1 ☐ Yes 2 ☐ XNo
	or 28	Director	10e. Street and Number				Zip Code			10		n of What Co	untry?
	eath v	erai	7902 Oakwood Rd.	2. Was Decedent Ever in U	I.S. 13		21061	spanic Origin	n? (Specify	Yes or No-	USA 14	Race - Amer	ican Indian.
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If Itan 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, the Modical Examilian must be notified at once.	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Kor		If Yes, sp	ecify Cuba 2∰ No	n, Mexican, F Specify:	Puèrto Rica	an, etc.)		Black, White	
2-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dec	edent's Us	sual Occupa	ation during most of	f working	10	6b. Kind	of Business/l	ndustry
121	within ene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ress)			Ner	spaper	
<u>م</u>	e filed Il Hygie other	Be Co	17. Father's Name (First, Middle, Last)			1033	lian	18. Mother's	Name (Fi	rst, Middle, Ma			
ylar	Menta Menta Merked Arked	ToB		eler				Barba				uskhor	
, Maryland 21215-0036	alth and 2 sh alth and 27 is m		19a. Informant's Name/Relationship (<i>Typ</i> Brenda Boteler (Da			_				Burni			
Baltimore,	Pages 1 annot of He ant: If Itsm ary or other		20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☐ Re	moval from State	Place of Dis cemetery, cr	ematory o	r other plac		Date			ition - City or 1	
<u>=</u>	it. Pag itment rtant: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Lo	udon I				/2/06	on Par			Maryland
Ba	Depa Impo any is		21. Signature of Fulleral Service Lice							Baltim			
	Pnysician		23a. Part1, Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.			17	g, such as ca	1 -		st,	į	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in usually	Due to (or as a consec	quence of):								
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of).								
	and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):								
8760,	icate be executed physicien and s the burial-transit	dical E	d.		,								
9	ortificat ing phy e as th	Medi	IF FEMALE:								_		
.O. Box	The law requires that the death certific ste hes been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	 c. If yes, outcome of pregnting the control of the cont	al death 3	□Ectopic □ Other (pregnancy (specify)				23	d. Date of deli Month	very Day Year
Ω.	es that the gned by be detac	by Ph	Part II. Other significant conditions cont	ributing to death but not re	sulting in the	underlying	cause give	en in Part I.				14	the cause of death?
örd	w require been si should I	eted							-	1 Tes			bably 4 Unknown
Vital Records,	To the Hospital or Attending Physicisn: The law within 24 hours alter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Completed								24a. Was an autopsy performed 1 Yes 2		prior to c death? 1 \(\subseteq \text{Yes}	opsy findings available ompletion of cause of
	Physicism: r this certifice ral director,	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2	Q R/Outpati	ent 3 🗆	Othe Othe	ar.		heck only one 5 □ Residen	6	701 (6	
Division of	g Phy ter this neral d	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time	of	28c. Injury	al		Describe how			iry)
sio	Attending or death. sctor: After by the fune	catic	☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			М	10	res 2□No					
Σ	s after of all Direct	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		street, faci	ory, office		281.	City or Town,	et and I State)	Vumber or Hui	ral Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medicai (29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	cian: To the best of my kn er: On the basis of examin- and manner stated.	owledge, de ation and/or	ath occurre investigation	ed at the time on, in my of	e, date and pointion, death	place, and occurred a	due to the cau it the time, dat	ise(s) ar e and pl	nd manner as lace, and due	stated. to the cause(s)
	To the Within To the compl	Me	29b. Signature and title of certifier)		2	9c. License	number		290	d. Date :	signed (Month	. Day, Year)
)	1		1 th /	Lamy M	9		0	1713)	J	uh	1 (3)	2006
`	DY,		30. Name and address of person who cor	npleted cause of death (ite	A	e, Print)	60 in	I Rate	200	O GLEW	URU	MANGE	2006 MO 25064
			31. Date filed (Month, Day, Year)	32. Registrar's Sign		-v -		0 -41	_ ,		- 1/ -	. 5/5 //	1 / //

			For State Registrar	State of Mary	•	artment of H			giene () () 6	241	64
j.	21	***	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day	Year	3. Time of D)eath
* 15.	Physicia /Medic		Tracey S	yvon	Braxt	on		July 30			1:30p	M
	Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or		eath	4c. County	of Death		
			Joseph Richey Hos		ven la at historia vi	Baltimo If Under 1 Year	re If Under 24	Hrs 9 Data of Rin	N/A	0 Rinth	place (State or	Comina
*	Funeral Director		5. Social Security Number 6. Sex 217-80-6255 □ Usual Residence of Decedent	M 28 F 44	yrs. last birthday) Yrs.	Months Days		Min (Month Day	6, 1962	Cou	ntrv)	roreign
	land ow		10a. State 10b. County	100	c. City, Town or Lo	ocation					10d. Inside City	Limits
	Mary 1 eh	ţō	Maryland N/A		Baltimor	e					1 🏿 Yes ∶	2 🗌 No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Cou	intry?	
	th with	alD	4617 Northwood Dri	ve		21239			USA			
	ems Fr	Funeral	11. Marital Status	Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	ispanic Origin In, Mexican, P	? (Specify Yes or No- querto Rican, etc.)	14. Rac Blac	e - Amer	ican Indian, , etc.	
36	or It		1 Never Married 2 Married	1 ☐ Yes 2 🛣No If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:			B1	ack	
Š	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show Inter than "natural", or Items of the notified at	d by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a Daga	dent's Usual Occup	ation	l d	16b. Kind of Bu	reinaes/l	ndustry	
<u> </u>	n 72 n n 72	lete	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	during most of f)	working	rob. Kind of be	13111033/11	idustry	
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Ö	e filed I Hyg oths	Bec	17. Father's Name (First, Middle, Last)		'		18. Mother's	Name (First, Middle,	Maiden Suman	10)		
<u>Ja</u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "natural", or Items 23a or 28a-f show aumatic event, the Medical Exercities in that be malified at	ToE	Charles H. Br	axton, Sr.			Betty		Clar			
Maryland 21215-0036	5 E Z = Z		19a. Informant's Name/Relationship (Type Betty J. Clark (Mot					e, Baltimo				
Ze,	of Hea		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	2 mount from State	Ob. Place of Dispo cemetery, cre	osition (Name of matory or other place	e)	Date	20c. Location -			
Ĕ	Page ment: It ant: It ury o		4 □Donation 5 □Other (Specify)	L		rk Cemete		/4/06	Baltimo			ıd
Baltimore,	permit. Pages 1 Department of H Important: If Ite eny injury or ot once.		21 Signature of Funeral Senine Ligense	-				Loudon Par ., Baltimo				
*	Physician / Medical Examiner pe procession and personnel	Examiner	23a Fart. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):	ter the mode of dyin	g, such as car	diac or respiratory an	rest,		Approximate Interval Betwood Onset and Do	reen
, P.O. Box 68760,	Physician: The law requires that the death certificate be this certificate hes been signed by the attending physicis at director, page 2 should be detached for use as the but	y Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con	ic. If yes, outcome of p 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3(of death 5(□Ectopic pregnancy □ Other (specify) underlying cause giv		23e. Did t	4	te of delin	Day Y	ear
ds	uires n sign iid be	d by	Acquired Imm	une Defi	ciency	Syndron	ne	1 🗆 1	Yes 2□No	3 ☐ Pro	bably 4 Ur	nknown
Vital Records,	Physician: The law rec this certificate hes bee ral director, page 2 shou	Completed	U						rmed?	prior to c death?	opsy findings a ompletion of ca	vailable use of
ta	an: T tificat tor, pë	BeC	25. Was case referred to medical				26. Place of	1 ☐ Yes Death (Check only of	-	1 1 105	2 No	
	yslci s cer direct	0	examiner? 1 Yes 2 No	ospital:	2 ER/Outpatie	nt 3□ DOA Oth	00	ng Home 5 ☐ Resid		er (Spec	150 HOSO	ice
Division of	Attending Ph ir death. sctor: After th by the funeral	atlon: T	27. Manner of Death 1. ■Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Ye	ar) 28b. Time (Wor	yat k? Yes 2 □ No		now injury occur	red		
Divis	al or Atts after des Directo d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	reet, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Ru	ral Route Numb	ΘΓ,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin one)	ician: To the best of mer: On the basis of exa	y knowledge, dea imination and/or in	th occurred at the tin	ne, date and p pinion, death	place, and due to the occurred at the time,	cause(s) and ma date and place,	anner as and due	stated. to the cause(s)	
	withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signe	d (Month	. Day, Year)	
)			> 2 SOIN	D		D	2417	20	July 3	1,2	306	
	2		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type	, Print)	01	Baltimore	112	.,		
			E. KOMD Kichey	Hospice	838 N	·Eutaw	St	Saltimore	, MD	212	01	
	Sta Regist		31. Date filed (Month, Day, Year) AUG 0 2 2005	32. Hegistrar's	Signature							

06-05376 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Brittany Braswell 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician*t* Month Day July 23, 2006 2145 hrs Medical Examiner Brittany Symone Braswell 4c. County of Death 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Prince Georges Medical Center Cheverly 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreian Months Davs Hours Director Country) Wash, DC 13^{Yrs} M 2 X F 02/18/93 Usual Residence of Decedent Oc. City, Town or Location 10d Inside City Limits ij 10a State 1 X Yes 2 No Dillion , or items 23a or 28a-f show r must be notified at once. SC Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 29536 300 S. 14th Ave Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 X Never Married 2 Married 2 X No Yes Specify: BLACK 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) n/a N/A N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sharon Diane Braswell Be Cornelius Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ျ Annie Braswell/Grandmother 300 S. 14th Ave Dillion, SC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 07/29/06 Suitland, MD Harmony Memorial 4 Donation 5 Other Specify: 22. Name and Address of Facility Signature of Funeral Service Licensee 5732 Georgia Ave. Švčs. Tri-State Funeral lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and 23a. Part I. Enter the disea Physician failure. List only one cause on each line. /Medical Death a. Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last transit The law requires that the death certificate be executed and Physician/Medical AMENDED attending physician or use as the burial -UNPENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Day Year 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 ✔ Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of certificate has b performed? death? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other₄ Hospital: 1 Nursing Home 5 Residence 6 Other: Inpatient 2 V ER/Outpatient 3 DOA After this 1 V Yes 28a. Date of Injury FOUND: 27. Manner of Death 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject hanged self FOUND: 1 Natural 1 Yes 2 V No 5 Pending To the Funeral Director: completely filled in by the 24 hours after death. Jul 23, 2006 2115 hrs Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) determined 5114 W. Mapleshade Lane, Upper Marlboro, MD (Specify) residence 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Assistant Medical Examiner

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

July 24, 2006

State

Registrar

29b Signature and title of certifier

31. Date filed (Month, Day, Year)

Patricia Aronica-Pollak MD.

AUG 02

30. Name and address of person who completed cause of death (Item 23a)

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tose Marie Boul	_	nt I- For State	St	ate of Mary	/länd /				id Wenta	'Hygiene		21	06	2416
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and the same		4a. Facility Name (4b. City, Town, o	r Location of D			c. County of	Death	
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Funeral		Social Security I	Number	6. Sex	7. Age	e (In yrs. las	t birthday)	If Under 1 Yea				/DD/YYYY)	9. Birthplace Foreign Vi	(State or
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th the Maryland 23a or 28a-f sho notified at once.	Director	9010 Br		t Lane				2070	R			US		
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and 2 shou lealth and N		Kevin Bo	ouknigh	t/Son		15				mase, A.				
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n of ling P After funera		27. Manner of Dea		Lui ^{(M}	ate of Inju onth Day Y 9, 2006	iry 2 (ear)	28b. Time of 1640 hrs	Injury 28c. Inj	ury at Work? Yes 2 ✔ No	Subject d		jury occurred vehicular	d r accident	
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		1	/ /	11	K.	N			.M.E.		Jul	y 20, 200	6	
U 1.		30. Name and add	dress of perso	n who completed	cause of c	eath (Item 2	ML,	/					-	
V		Theodore	M. King, Jr	., MD. Ass	istant M	ledical Ex	kaminer	111 Penn S	treet, Baltir	more, MD 212	201			

State 31. Date filed (Month, Day, Year) Registrar

32. Registrar's Signature

ORIGINAL ORIGINAL

Registrar

AUG 0 2

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** OAM 28 rene /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** Ral NA If Under 24 Hrs. 8. Date of Birth Min Month, Day, Homewood are If Under 1 Year Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2001F 215 32 640 Yrs. 88 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location orient: if item 27 is marked other then "natural", or items 23a or 28e-f show injury or other treumatic event, the Medical Examinat must be rediffed at Md. Baltimore ÑΑ 1X Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21202 USA 1000 Wilmont Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. snt: If item 27 is marked other then "natural", or Ite 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Other People Homes 4th grade Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Jones Candice Davis Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Winters Lane Apt.329, Baltimore, Md. 21228 Candice Fullwood Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department o Importent: # any injury or Arbutus Mem. Pk. 8-3-06 Arbutus, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. مسور odip Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician End Store /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last Cansestive Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of): sician P.O. Box 68760 Physician/Medical attending physical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 menths? 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death! Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 2 No 1 Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 2 No 1 Tyes 3□ DOA 4 Voluming Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Plospitel or Attending Plant 24 hours after death.
Funerel Director: After the 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifier 9056 MO 1 s of rerson who completed cause of death (Item 23a) (Type, Print) 30. Name and

State Registrar 31. Date filed (Month, Day, Year)

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			1 - For State Amend item#29dpe	State of Ma erMD,G858,8/	aryland / De /2/06 TT C	partmen ertificat	t of H	ealth a D <i>eath</i>	and M	ental Hyg	jiene []	06	24169
			1. Decedent's Name (First, Middle, Last)							2. Date of Dea		Vana	3. Time of Death
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			Mariner Health at	North A	runde1	Gle	n Bu	rnie			Anne	Arud	e1
₹.	Funeral Director		5. Social Security Number 6. Sex 364-24-1148	7. Ag	e (In yrs. last birthd 82 Yrs	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day July 26	, Year) , 1924	9. Birth	place (State or Foreign ntry) MI
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event. It a Madicial Examinar must be notified at anose.	by Funerai	1 □ Never Married 2 🔀 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	If Yes, spe		Specify:	, Puerto F	cify Yes or No- Rican, etc.)		ck, White,	
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Baltimore, Maryland	Pages 1 ment of H ant: If ite ury or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R □ Donation 5 □ Other (Specify)	emoval from State	Meadowr	crematory or c	ther place	θ) A	ugus 2000	tl,	20c. Location		
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	he Ho in 24 t he Fu pletely	edicai	(Uneck only 2 Medical Examin one)	er: On the basis of and manner sta	examination and/o	investigation	, in my op	inion, deat	h occurre	d at the time, d	ate and place,	and due to	the cause(s)
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2/	5	(Honra M	Evereli	4 m.0	1	0.00	254	739	1	JULY !	31344	2009 .
(1	30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Ty	oe, Print)	١٠٠٠		1	will .	No. 7		
200	Sta	to	31. Date filed (Month, Day, Year)	32. Registe	ar's Signature	40		HACY	18	110.7	1061		
*	Registr		AUG 0 1		man S.	Spar							

State of Maryland / Department of Health and Mental Hygiene) For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Currie Rosalia M. /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Ruxton Nursing Home Of Pikesville Pikesville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sax **Funeral** Min. Months Hours 1 M 2 XF Days 92 12/19/1913 Maryland Director 214-22-2397 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 28a-f show f Health and Mental Hygiene. Item 27 Is marked other then "natural", or items 23a or 28a-1 ehov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No BALTIMORE Woodlawn Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with U.S.A. 7132 North Alter Street 21207 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 Specify: Specify: Black 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Housekeeper permit. Pages 1 and 2 should be file.
Deparment of Health and Mental Hygin Important: If Item 27.1s marked eny injury or other 17. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Tyler / Caretaker 7132 North Alter Street, Woodlawn, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 08/03/2006 Woodlawn, Maryland ture of Funeral Salvine Lice 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Pan1. Enter the disease, or complication: hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ereBIAC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): **Box 68760**, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? World 4 Pregnant at time of death 5 Other (specify) P.O. P 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, ate has been signe page 2 should be 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy rmed? 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No After this c Certification: To 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes death. investigation the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Hospitel or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of entifier 29c. License number 30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print) Dr. Harold Bob 31. Date filed (Month, Day, Year) 25 Main Street, Suite 200, Reisterstown, Maryland 22. Registrar's Signature State GORALL Registrar AUG 0 2 2006

Please Type or Print in Black Indelible Ink

	State of Maryland / Departmen 1- For State Certificate		ygiene Reg No. 200	6 2417
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle,Last) JOHN RICHARD CARTER		2. Date of Death Month Day Year July 26, 2006	3. Time of Death 2200 hrs
	4a. Facility Name (if not institution, give street and number) Sinai Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	4b. City, Town, or Location of Death Baltimore If Under 1 Year If Under 24Hrs	NA	
Funeral Director	217-66-6684 1XM 2F 49	Yrs. Months Days Hours Min	TTTY 20 1057 Foreig	
Baltimore, MD 21215-0036 pennit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County NA RARYLAND NA RALTIMORE 10c. City, Town or L RALTIMORE 10c. City, Town or L RALTIMORE 10c. City, Town or L RALTIMORE 10c. City, Town or L RALTIMORE 10c. City, Town or L RALTIMORE 11c. Was Decedent Ever in U.S. 11c. Was Decedent Ever in U.S. 11c. Yes 2 X No 11	10f. Zip Code 21.21.5 Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerto Yes, 2 X No specify: edent's Usual Occupation (Give kind of ving most of working life. DO NOT use retired to the company of the compa	Rican, etc.) White, etc. Specify Work done red) FNTREPRENEAU (First, Middle, Maiden Surname) BRADFORD Rural Route Number, City or Town, State RE, MARYLAND 21218 Date 20c. Location - City or 5, 2006 RALTIMORE, M JIE FUNERAL HOME P.A.	ican Indian, Black, ACK Industry JR e, Zip Code) Town, State
be executed by Medical and unial - transit edical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	g858 8-2-06 vt	23d. Date of deliver	Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b Medical Certification: To Be Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in 25 Was case referred to medical examiner? 1 Yes 2 No 9 Unknown 9 Unknown 1 Hospital: 1 Inpatient 2 ER/Output	26 Place of Death (Check atient 3 DOA Other,4 Nursine of Injury 25c. Injury at Work? D: 1 Yes 2 No n, street, factory, office building, etc. occurred at the time, date and place, an estigation, in my opinion, death occurred	autopsy performed? 1 ✓ Yes 2 No 1 ✓ Y conly one) ng Home 5 Residence 6 Other 28d. Describe how injury occurred Subject was shot 28f. Location (Street and Number or R or Town, State) 2602 Loyola Southway, Baltind due to the cause(s) and manner as state	utopsy findings available completion of cause of les 2 No No No No No No No No No No No No No
State Registral	31. Date filed (Month, Day, Year) AUG 0 2 2006 32. Figistrar's Signature	O.C.M.E. Street, Baltimore, MD 21201	July 27, 2006	
DHMH 17 Rev 1/2001	ORIC	ŠINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) David McNamee Clattenburg Sr. 2. Date of Death 3. Time of Death . 2006 July **Physician** -David - McName Clattenburg, Sr. 31, 8:52pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Eldersburg

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.
Aug 29, 19 6007 Kennard Court Carrol1 9. Birthplace (State or Foreign Country)
MD 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 🙀 M 2 🗆 F 76 Yrs. Director 212-24-8481 1929 Usual Residence of Decedent deeth with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Iteme 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Hudson Director NJKearny 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 200 Hickory Street 07032 Funerai permit. Pages 1 and 2 should be filed within 72 hours after deel Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ Item 2000. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tyes 2 No
If Yes, Give
Year or Dates: 1946-49 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☒ Divorced Completed 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clergy / Sales Minister/Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sylvia McNamee Alexander H. Clattenburg ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sharon K. Pullman (Daughter) 6007 Kennard Ct., Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/4/2006 Moreland Mem. Park Parkville, MD 21. Signature of Funeral Service License HATGHT FUNERAL HOME & CHAPEL, PA Box 195) tuckt - K. Sykesville, MD 21784 (410)-795-1400 Sykesville, MD 21784 (410)—
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final slow Caucer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Knowh 1 Yes 2 No 3 Probably 4 Whiknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy perfo 1 Yes To the Hospital or Attending Physicien: ours after death.

nerel Director: After this certific filled in by the tuneral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Daughter ဥ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: hone 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after on Funerel Direc determined 4 Thomicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 24 ho To the Fune completely fi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1171

DHMH 17 Rev 1/2001

State ³ Registrar

31. Date filed (Morith, Day, Year)

AUG 0 2 2006

Registrar's Sign

Sacontz

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, m. P.

015552

SI

Westminster md.

8/1/06

State of Maryland / Department of Health and Mental Hygiene' [] [] 6 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day July Year 29, **Physician** Frances S. Clark 2006 8:10 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Corsica Hills Nursing Home Queen Annes County Centreville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. (Month, Day, Year)
Aug. 28, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 200F Months 87 Yrs. 220-09-4514 Maryland Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan near of Health and Mental Hygiene.
ant: If item 27 Ia marked other than "naturat; or Items 23a or 28a-f ehow ury or other traumatic event, I'm Medical Examinat man Landillish at ury or other traumatic event, I'm Medical Examinat man Landillish at Baltimore Maryland Catonsville 1 ☐ Yes 2 X No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16 Fustings Avenue 21228 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fabric Cutter Clothing Migr. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Struck Carrie Christopher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry V. Clark 36 Capetown, Berlin, MD 21811 (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 8/2/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 1 Jenent disease or condition resulting in death) >0-/Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner physician and sthe burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Day 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 21/11No certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one examiner Other: 4 Sursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 Tatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 124 hours after the Funeral Dire Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho To the Func completely f (Check only one) and manner stated. 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint) ante Mas 2108 H 173 Drave 31. Date filled (Month, Day, Registrar's Signature State 2 2006 AUG 0 Registrar

			For State Registrar	State of Ma			nent of H cate of L		nd Mental	Hygie Reg.		06	24171
	Dhusiai	·g-	1. Decedent's Name (First, Middle, I	ast)					2. Date		Day	Vear	3. Time of Death
à	Physici /Medic		John Joseph De	nnis II					July	'	29, 2	2006	6:42 A M
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*	Funeral Director		5. Social Security Number 6. 469-22-2250 Usual Residence of Decedent	Sex 7. Age	(In yrs. last bin		iths Days			h, Day, Ye	^{ar)} 1926		lace (State or Foreign try) nesota
	land ow		10a. State 10b. County		10c. City, Town	n or Location	1					11	0d. Inside City Limits
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	r 28e	rec	10e. Street and Number				f. Zip Code			10g.	Citizen of W	/hat Coun	try?
	th wit	Funeral Director	219 South Southwo	ood Avenue			2140	1			USA		
	ems erms	Iner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was D	ecedent of Hi	spanic Origin n, Mexican, F	? (Specify Yes o	or No-		- America	an Indian,
36	s afte	by Fu	1 Never Married 2 Married	If Yes, Give	1943		es 2 XNo	Specify:		,	Specify:	T 70 .	
Ş	turai i Ex		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	1946	Decedent's	Usual Occupa	tion		166			
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وّ	Pages nent of H		1 Burial 2 XCremation 3		20b. Place of cemeter						Location - (•	
altimore,	permit. Pages Department of Important: If it any Injury or o		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice	5	Metro		tory In		7/31/06	Ва	<u> Itimoi</u>	ce, M	Maryland
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			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused to	he death. Do r	not enter the	mode of dying	, such as ca	rdiac or respirato	ry arrest,	,	/ Land	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):							
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oj.	0 0 0	Physician/M	1 Yes 2 No	4□Pregnant at t 9□Unknown	me of death	5 🗌 Othe	r (specify)			- "	Mon	(f)	Day Year
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DIVISION	F 9 F C	Certification:	4 Homicide determine		y - At home, far (Specify)	m, street, fa	ctory, office		28f. Locati City or	on (Street Town, St	and Number ate)	r or Rural	Route Number,
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	e Hos	edicai	(Check crity 2 Medical Ext	aminer: On the basis of e and manner state	examination and	d/or investiga	tion, in my opi	inion, death o	occurred at the ti	me, date a	ind place, ar	nd due to	the cause(s)
	To the Hospital c	Me	29b. Signature and title of certifien				29c. License			29d. [Date signed	(Month, D	(ay, Year)
,	,		Jewn Ill	un les	7		130	218		0	7-31	.200	06
	22+1		30. N me and address of rerson who	completed cause of de	ath (Item 23a) (Type, Print)	4	76-	up				
	Δ,			26 020 57	uesa	CNZZ	e Clar	040	NID	210	2		
100	Sta Registr		31. Date filed (Month, Day, Year) AIIC 0 2	2006 32. Hardistrar	s Signature	1004	N.						

			For Stata Registrar		State of M	aryland .		artment of H rtificate of L		Mental Hy	giene Reg. No	2006	24175
	Dis		1. Decedent's Nam	e (First, Middle, Las	t)					2. Date of De	aath Da	y Year	3. Time of Death
	Physici /Medio		Join	Doty						01	20		05155AM
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death	1	4c	. County of Deat	h
	Funeral Director		5. Social Security N 213-68-	-9535 ¹¹		95 (In yrs. last 49	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Mar 12	rth 3 ^y 1 ^{Year})	Both may 9. Bird co Mar	hplace (State or Foreign untry) yland
	and w		Usual Residence o	f Decedent 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
	Maryla f eho	ō	Md.	n/a			timo						X∐Wes 2 □ No
	the the 28s-	rect	10e. Street and Nu			Dal	LIM	10f. Zip Code			10a. Cit	izen of What Co	untry?
	3a or		3609 Hu	idson St	reet			21224				USA	,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 ie marked other then "natural", or items 23s or 28s-f ehow other traumatic event, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Marr 3 Widowed	ried 2K Married	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give	?		Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	D-	14. Race - Ame Black, White	e, etc.
21215-0036	turai	ed p	3 🗆 WIGOWEG	15. Decedent's Ed	Year or Dates:	1	6a Dece	dent's Usual Occupa	tion		16h K	ind of Business/	hite
15	in 72 n "ne	Completed		cify only highest grad	de completed)		(Give	kind of work done d DO NOT use retired)	uring most of wor	king	100. 10	ind of business/	inoustry
212	filed within Hygiene. other then "	Eo	Elementary/Second 12	ondary (0-12)	College (1-4or:	5+)	Reg	gistered	Nurse		Me	dical	
	e file othe vent,	0	17. Father's Name	(First, Middle, Last)					18. Mother's Nam	ne (First, Middle	, Maiden	Sumame)	
<u> a</u>	uld be Aenta rked tic ev	ToB	Franc	cis Mer	riken				Agnes	Imbie	erow	icz	
Maryland	2 should be f and Mental H ie marked of eumatic eve		19a. Informant's N	ame/Relationship (7	ype, Print)	1	19b. Mailir	ng Address (Street a	nd Number or Ru	ral Route Numb	er, City o	or Town, State, Z	lip Code)
	1 and 2 Health tem 27			R. Doty	(husban	ıd)	3609	Hudson	Street	Balti			
ore	ges 1 ar t of Hea if item or other		20a. Method of Dis	position Cremation 3	Removal from State	ceme	etery, cren	sition (Name of natory or other place)	Date		ocation - City or	
Ë	Pages ment of I tant: If its			5 ☐ Other (Specify		St.S		slaus C				timore	•
Baltimore,	permit. Pages Depertment of the important: if its ony injury or of once.		1 Tola	uneral Service Licen	Jank	\	12	201 Dund	alk Ave	enue Ba	alti		1 Home, PA Md. 21222
	Physician /Medical		shock, or hea lmmediate Cause disease or condition resulting in death)	the disealle, or comp art failure. List only o (Final on	a. Pulm	ine.	Embo	//is-y	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner		Convention to lies on	anditions.	h		ŕ						
	₽ =	ner	Sequentially list concause. Enter Under Cause (Disease or	nmediate -	Due to (or as	a consequen	no of):		•				
	icate be executed physicien and s the burial-transit	Examiner	Cause (Disease or that initiated events resulting in death)	S	с.								
90,	oe execien a	ũ	resulting in death)	Last	Due to (or as	a consequen	C9 Of):						
68760,	icate be ex physicien s the buria	edlcal			d								
Box.	ne death certif the attending thed for use a	Physiclan/Me	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [9% Unknown	months?	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□ Unknown	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)				23d. Date of deli Month	very Day Year
Records, P.O.	quires that the signed by all did be detected	by	Part II. Other signi	ficant conditions co	ntributing to death b	out not resultin	ng in the ur	nderlying cause give	n in Part I.		obacco t		the cause of death?
000	aw requir is been si 2 should I	Completed								24a. Was		24b. Were au	topsy findings available
æ	The law	E									psy ormed? 2 ☐ No	death?	ompletion of cause of 2 No
Vital	sician: The certificate ha	0	25. Was case refer	rred to medical					26. Place of Dea			174 165	2 140
/	ıysici iis cə dirəc	To B	examiner? 1 ☐ Yes 2 🔀	(No	Hospital: 1 Inpatie	ent 2 ER	/Outpatien	t 3 DOA Othe	r: 4 Nursing H	ome 5□Resi	dence	6 □Other (Spec	ufy)
υot	ding Ph h. After th funeral		27. Manner of Deat		28a. Date of Inju		b. Time of Injury	28c. Injury Work		28d. Describe			,,
Ö	ath. or: Af	atlo	1 X Natural 2 ☐ Accident	5 ☐ Pending investigation		, , , , , ,	,,		es 2 □No				
Division	tal or Attenders after deatles al Director: ed in by the	Certification:	3 Suicide 4 Homicide	6 Could not be determined	289. Place of in	jury - At home tc. (Specify)	, farm, str	eet, factory, office		28f. Location (. City or To			ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the fune	Medical	29a, Certifier (Check only one)	2(Medical Exam	sician: To the best iner: On the basis o and manner st	t examination	and/or inv	restigation in my on	inion, death occur	rred at the time	date and	nlace and due	to the cause(a)
	With To 1	Σ	29b. Signature and	title of certifier)			29c. License	number		29d. Dat	te signed (Month	, Day, Year)
				The by	1,10			AT243	88946-F3	3	0	7-30-	2006
1.	1		30. Name and add	ress of person who o	ompleted cause of o	death (Item 23	a) (Type,	Print)			==,		1
6	/			ustin C	roy, 10			Union M	emorial.	Hospilal	Bal	Honory	MN
	Sta		31. Date filed (Mor.	nth, Day, Year)	32 Registr	rar's Signature	La	cale		/		, -	
DH	Registi	-	- F	title of certifier ress of person who country, Day, Year) IUG 0 2 200	JO LANGE	See als.	F						

ORIGINAL

			For State Registrar		artment of Health and N rtificate of Death	Mental Hygie	(U U U	24176
	Dhusiai		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al	CIENN	1 Jargar		0+	2 Zear 4c. County of Death	3
	Examin	er	4a. Facility Name (If not institution, give street	Les (are	4b. City, Town, or Location of Death	are)	W /	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Ye	9. Birthr	place (State or Foreign
	Director		239-40-2602 1XM	15 Yrs.		Rb: 15,1	931 nor	to Carolina
	yland Now		10a. State 10b. County	10c. City, Town or L	ocation		1	10d. Inside City Limits
	Ba-fsl	Director	ma. NA	/<	Sattemore	<u> </u>		1 Yes 2 No
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has the marked other then "netural; or items 23s or 28s-f show other treumatic event, the Mudical Examinations the notified at	i Dire	10e. Street and Number 27 06 Flmo	1a Are	10f. Zip Code	10g.	Citizen of What Cour	A A
	ems 2:	Funeral	11. Marital Status	/as Decedent Ever in U.S. 13. med Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Americ Black, White,	
36	72 hours after netural', or ite	by Fu	1 Never Married 2 Married 1	Yes 2 □ No Yes, Give ear or Dates:	1 ☐ Yes 2 No Specify:		Specify:	Black
2-00	72 hou netura lical E	ted	15. Decedent's Education (Specify only highest grade con	n 16a. Dece	edent's Usual Occupation a kind of work done during most of work		. Kind of Business/In	ndustry
21215-0036	within ene. then "	Completed			DO NOT USO retired) Contr	actor (onstr	iction
	il Hygie other	Be Co	17. Father's Name (First, Middle, Last)	NI/F		ne (First, Middle, Maid	den Sumame)	
ylar	2 should be and Mental Is marked c	To E		gan	Ju	cha f	arke	
Maryland	id 2 sh Ith and 27 Is rr treurr		19a. Informant's Name/Relationship (Type, France France)	an II	ing Address (Street and Number or Rui Elmora De Ba		ty or Town, State, Zip 2-1 2-1	Code)
ore,	of Health of Health fitem 27 r other tr	1	20a. Method of Disposition	20b. Place of Disponentary, cra	C I I I I I I I I I I I I I I I I I I I	1	Location - City or To	own, State
Baltimore	Pages ment of tent: If it jury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify	Bamson	Forest vet 8-	4-06 0	Winom	ills, mD,
Ball	permit. Pages Department of Importent: If i any injury or once.		21. Some of Funeral Service Licens a	1.00000	au (g in . ivallale	Funeral Se	in It	to, md, 21229
	- 1		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the death. Do not en		1		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Liver t	-allure			Onset and Death
	/Medical Examiner		Tosulary in double)	Due to (or as a consequence of):	Neuplasm	-Unipec	-6941	
C	.70 ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a corts quence of):	1,100			
10	death certificate be executed e attending physician and of for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Lasi	Due to (or as a consequence of):				
8760	le be e ysician e buria	dical E	L d					
68	rtificat ng ph) as th	Medi	IF FEMALE:					
Вох	death certifics attending phate as to	Physician/Me	23b. Was decedent pregnant		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver	rery Day Year
Ö	that the de ed by the detached	hysic		Unknown				
S, D	es De	by P	Part II. Other significant conditions contribu	ting to death but not resulting in the	underlying cause given in Part I.		co use contribute to to	₩ ²
Records	requi	eted				1 ☐ Yes 24a. Was an		opsy findings available
Rec	e las	Completed				autopsy performed	prior to co death?	empletion of cause of
Vital	ian: The	BeC	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	10 12.55	
of <	Physician: this certific ral director.	ျ	1 ☐ Yes 2 No Hospi	1 Inpatient 2 EH/Outpatie			e 6 □Other (Specif	fy)
		tion:	Tatalara Di Tomang	Ba. Date of Injury 28b. Time ((Month, Day Year) Injury	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how i	nlury occurred	
Division	A 2 8 9	Certification:	a The state of the Could get be	Be. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura itate)	al Route Number,
Ö	oital or urs afte ral Din							
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	(Check only 2 Medical Examiner:		th occurred at the time, date and place, nvestigation, in my opinion, death occur			
	To the within 2 To the comple	Me	29b. Signature and title of certifier	Ziaz Mirza	mo 29c. License number	~ 1 29d.	Date signed (Month,	Day, Year)
	1		-au		(, , ,	0 1	T 01-	- 06
	X		30. Name and address of person who completed in the second	1 Worth Cha	Merst Lowro	" WW	51501	4
	Sta Regist		31. Dale filed (Month, Day, Year) AUG 0 2 2006	32. Figistrar's Signature	Link .			
	negist	rall	ACG 0 2 2000	PERSONAL POR				

			For State Registrar		State of	Marylan	d / Dep <i>Ce</i>	artmer rtificat	nt of H	ealth a Death			Reg. N) 6	24	177
	Physici	an	Decedent's Name									2. Date of De Month	D	,	'ear	3. Time	М
	/Media	cal	Catheri:		Erlbeck give street and numb	er)		4h City	Town or	Location of		July	28,	200 c. County of		545	Α
	Examir	ner	Ruxton			.,			nton		200			aro1			
	Funeral		5. Social Security N		. Sex 7.	Age (In yrs.	last birthday)		r 1 Year	If Under 2 Hours	4 Hrs.	8. Date of Bir (Month, Da	th	9		lace (State	or Foreign
	Director		213-09-		1 □ M 2 □XF	8.5	Yrs.	INIOTHIO	Days	110013		Oct.				MD	
	and w		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or L	ocation							1	0d. Inside	City Limits
	Maryl	tor	MD	Caro	line	De	nton									1 ☐ Ye	s 2 No
	h the	Director	10e. Street and Nu	mber			-	10f. Zip	Code				10g. C	itizen of Wh	at Cour	ntry?	
	th wit	aiD	420 Col	onial 1	Orive				629					SA			
	tems	Funerai	11. Marital Status		12. Was Decede Armed Force	es?	.S. 13.	Was Dece If Yes, spe	dent of Hi	spanic Orig n, Mexican,	jin? (Spec Puerto F	cify Yes or No lican, etc.))-	14. Race - Black,	Amend White,		
36	rs afte		1 ☐ Never Marr 3 █ Widowed	ied 2 Marrie 4 Divorced	d 1 Tes 2 If Yes, Give Year or Date			1 ☐ Yes	∑ No	Specify:				Specify: 1	Whi	te	
5-0036	72 hours after death with the Maryland natural', or items 23a or 28a-f show dicel Examiner must be rodified at	Completed by		15. Decedent's	Education		16a. Dece	dent's Usu	al Occupa	ation			16b.	Kind of Busi	ness/in	dustry	
215	within 7. ene. than "n	ple	(Spec	, , ,	grade completed) College (1-4	or 5+)	life.	DO NOT u	ork done d ise retired	furing most)	or workin	g					
2	filed wi Hygien ether th		7				s	ecre	tar		L. Maria	/5' A4'-4-#-		usin		Mgt	•
gue	be fill ad off	Be	17. Father's Name									(First, Middle			1		
Maryland	should the not marked umarked	은	George				19b. Maili	na Addres	s (Street a	-		t Hec			ate. Zip	Code)	
	nd 2 s lith ar 27 is r trau				s - Daug	hter		•				Dunda					
ore,	of Heal		20a. Method of Dis		□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	20b. P	Place of Disposemetery, cre	osition (Na matory or	me of other plac	e)	Da	ate	20c. I	Location - Ci	ity or To	wn, State	
Ē	Page nent c ent: if ury or			□ Cremation 3 5 □ Other (Spe	B □Removal from St ecify)	ale	k Law	n Ce	met	ery 8		06					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. importent: if item 27 is marked other than "natural", or items 23a or 28a-f show amy lojury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Fu	Ineral Service Li	censee							dley- Sprin					HOme
	Physician /Medical		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	irt failure. List oi (Final on		ised the death th line.	1 0					2153	rrest,			Approximately Interval Brown Consett and C	Death
8760,	ate be executed hysician and the burial-transit	lical Examiner	Sequentially list or if any, leading to ir cause. Enter Unde Cause (Disease or that initiated event resulting in death)	injury s	b. AT Due to (or	as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of	SCL&					الد ل	K	DIKA	14	464 464	ns es
O. Box 6	death certifi e attending p d for use as	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	months?		h 2 ∏Feta ntattime of d	death 3	⊒Ectopic p ⊒ Other (s						23d. Date of Month		ery Day	Year
ds, P.	Se us		Part II. Other signi	ficant condition	s contributing to dea	th but not res	ulting in the c	anderlying AL	cause give	en in Part I. LICF (1	いをん			use contrib	ute to th		f death?]Unknown
Records,	> 2 5	lete	DEM	ENTIA			7-1				/	24a. Was	an	24b. We	re auto	psy finding	s available
al Re	The ete h. page	Completed by										1 Yes	ormed? 230 N	dea	or to con ath? Yes	mpletion of 218 No	cause of
₹	Physicien: this certific ral director.	To Be	25. Was case reference examiner?	No	Hospital:	patient 2	ER/Outpatie	nt 3 D	OA Othe	. O.S.	rsing Hor	(Check only only only only only only only only		6 □Other	(Specif	y)	
o	ding Phy I. After thi funeral o		27. Manner of Dea	th	28a. Date of		28b. Time of		28c. Injun	The state of the s	-	8d. Describe				,	
io	tendin death. tor: Aff the fur	atio	1 Natural 2 Accident	5 Pending investiga	ation		,,	М		Yes 2□N	No						
Division of Vital	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funera	Certification:	3 Suicide 4 Homicide	6 Could no determin		f Injury - At h g, etc. <i>(Specif</i>	ome, farm, st	reet, factor	ry, office		2	Bf. Location (City or To			or Rura	l Route Nu	mber,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one)		Physician: To the bas and manne	is of examina											(s)
	To t Withi To tl	Ž	29b. Signature and	title of certifier					c. License	e number	-0.1	L	29d. D	ate signed (
	/		14	mer	Z ATT		6 M		D60	723	U74		0	7-2	8-	90	
	5		30. Name and add	ress of person w	ho completed cause	of death (Iter	m 23a) (Type			16 3 A	u	Cun.	20	SIRIO	ارا	BN	
	St	ate	31. Date filed (Mor	nth, Day, Year)	32 Re	gistrar's Signa	ature	DCPL	· · · · · · · · · · · · · · · · · · ·	NEO		1 200	C. 11	~ 40 1	- []		
	Regist		n	HC 0 2 2	006	was h	7 As	2462									

		-	State of Maryland / Dep State Registrer State Of Maryland / Dep	artment of Health and M ertificate of Death		ene2006	24 70
			1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
ı	Physicia /Medic		Archie C. Freeman		Month 07	27 06°	9:00 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Silver Spring		Montgomer	
	Funeral			If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	 Date of Birth (Month, Day, Y 		lace (State or Foreign htry)
l,	Director	-	252-05-9412 1XJM 2LIF 93 Yrs.		11 28 1	2 Sout	h Carolina
	and and	}	10a. State 10b. County 10c. City, Town or L	ocation		1	0d. Inside City Limits
	Mary f ehc	jo	D.C. Washing	aton			1X Yes 2 □ No
	the 286	rec	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cour	ntry?
	3 with	Funeral Director	736 Quebec Place N.W.	20010		USA	
	death ms 2	era	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If it tem 27 is marked other than "naturel", or items 23a or 28e-f show or other treumatic event, the Madical Examination must be notified at or other treumatic event, the Madical Examination.	by Fur	Armed Forces? 1 □ Never Married 2 □ Married 1 □ X Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ② No Specify:	ricall, etc.)	Black, White, Specify: BLac	
Maryland 21215-0036	2 hou	ed		edent's Usual Occupation		6b. Kind of Business/In	dustry
15	n n	Completed	(Specify only highest grade completed) (Giv. Elementary/Secondary (0·12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)			
2	d with	E		curity Guard	\ L	I.S. Govern	ment
פ	e filed Il Hygid other vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	aiden Sumame)	
<u>a</u>	Ald by Alenta Al	To E	Powell Freeman	Corrie	Freeman		
ary	2 should be and Mental le marked eumatic ev		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ling Address (Street and Number or Run	al Route Number, (City or Town, State, Zip	Code)
	and 2 ealth a n 27 I		Vallie D. Byrdsong III Son 1041. 20a. Method of Disposition 20b. Place of Disp	6 Deakins Hall Dr.	Adelphi.	MD. 20783	
ore.	of He fiterr	10 3	Certification, Cree	6 Deakins Hall Vt., position (Name of ematory or other place)	Date	c. Location - City or To	own, State
Ĕ	Pages nent of int: If the iry or o		1 Burial 2 □ Cremation 3 □ Removal from State Under (Specify) Maryland	National Pk. 8-3-	·06 L	aurel, MV.	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any njury or other to once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility $M\omega$	ishall's	Funeral Hor	ne
œ	88 = 8	8 1	P Marshall	1217 9th. St. N.W.	Washingt	con, D.C. 2	0011
			23a. Part 1 Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on ea 1 line.	nter the mode of wing, such as cardiac	or respiratory/arre	ft,	Approximate Interval Between
	Physician	0.0	Immediate Cause (Final disease or condition	Keshization	1 141	11800	Onset and Death
	/Medical		resulting in death) Due to 'or as a consequence of):	11 11	1700	1	1, //
	Examiner		Sequentially list conditions b. Conglet	ine Heast	Hay	litre	Tonthe
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		7/		
	and trans	Examiner	that initiated events c.		<u> </u>		
0	ate be executed hysicien end ihe burial-transit	<u> </u>	resulting in death) Last Due to (or as a consequence of):				
8760,		dicai	d				
9	The law requires that the death certific ste has been signed by the attending p cage 2 should be detached for use as.	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			20d Date of delice	
Вох	ath c	an	230. Was decedent pregnant 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver	Day Year
	the a	ysic	1 Tes 2 No 9 Unknown				
P.O.	hat il	F.	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
ds,	signe d be	b	Christic obstruct	tule Pistmone	1 ☐ Yes	2 □No 3 Prot	oably 4 Unknown
0	regu	Completed	Alacar.	The property	24a. Was an		
€C	elaw hast	idu	- CVICIA	/	autopsy performe	prior to co	psy findings available mpletion of cause of
H F	: Th					No 1 ☐ Yes	2 No
Ž.	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:	Other	h (Check only one,		
of	Phys this al dii	. To	1 ☐ Yes 2 ☒ No rospital: 1 ☒ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time	BIL 3 DOA 4 Hutsing He	me 5∐ Residen 28d. Describe how	ice 6 Other (Special vinium) occurred	ý)
Z	Jing After funer	ion	1 Natural 5 Pending (Month, Day Year) Injury			,,	
isi	Attending r death. sctor: After by the fune	Ca	3 Suicide 6 Could not be 399 Bloom of Injury At home farm of		28f. Location (Stre	eet and Number or Rura	al Route Number.
Division of Vital Records,	after Direction by	Certification:	4 Homicide determined building, etc. (Specify)	,,,,	City or Town,	State)	
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificete has completely filled in by the funeral director, page 2		29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, det				
	ne Ho n 24 l	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, dat	te and place, and due t	o the cause(s)
	To the Hospitel within 24 hours a To the Funerel I completely filled	Ž	29b. Signature and title of certifier D. Quill	29c. License number	290	d. Date signed (Mont).	Day, Year)
	T		Comair of	D2870	20 11	7/28/0	6
	101		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	K	16 B	conbelt.
	U		SURINDER SINGY	1319 A Hane	des 1an	Lway. MI	2000
16		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1		1/	
15	Regist	rar	AUG 0 2 2006	Cosses			

			For State of N	Maryland	l / Depa <i>Cer</i> i	rtment of H	lealth and M <i>Death</i>	lental Hygie Reg.		16	24179
-			Decedent's Name (First, Middle, Last)					2. Date of Death	D	,	3. Time of Death
3	Physicia		Nancy E. French					July 31,	2006	'ear	9:00 A ^M
i in	/Medic		la. Fecility Name (If not institution, give street and number	er)		4b. City, Town, o	r Location of Death	322)	4c. County of	Death	
**	Examin	E1	7734 Washington Blvd. #53			Elkrid	σ ο		Howard		
3	Funeral			Age (In yrs. la:	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	205)	9. Birthpla	ace (State or Foreign
** ***	Director		253-56-3594	68	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Apr. 2,	1938 C	eorg	
- C			Usual Residence of Decedent								
2	how		10a. State 10b. County	10c. City,	Town or Loc	ation				10	d. fnside City Limits 1 ☐ Yes 2 No
Ž	tifie	cto	MD Howard	E1k	ridge						
Ę	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	. Citizen of Wh	at Count	ry?
£ .	23s	18	7734 Washington Blvd. #53	3		2107			US		
a do	E D	Funeral	11. Marital Status 12. Was Decede Armed Force	s?	. 13. W	las Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	White, e	
မ္ဘာ	卢를	y Fu	1 Never Married 2 Marned 1 ☐ Yes 2 If Yes, Give		1	□Yes 2 No	Specify:		Specify:	7 .	
1215-0036 within 22 hours after death with the Maryland	ural al Ex	d by	3 ☐ Widowed 4 ☐ Divorced Year or Date	s:	16a Docad	ent's Usual Occup	whi		b. Kind of Busi	whi	
5	a dia	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give k	and of work done O NOT use retired	during most of work	ing	o. King or Busi	11033/1110	zatry
2	then.	m d	Elementary/Secondary (0-12) College (1-4)		Manage	r		1	Apartme	nts	
ם ס	ntal Hygiene.		17. Father's Name (First, Middle, Last)			_	18. Mother's Name	e (First, Middle, Ma			
8	sed of c	То Ве	Shirley T. Hammonds				Mvrtle	Davis			
Maryland 21215-0036	mar mat	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	Address (Street	and Number or Run	al Route Number, C	ity or Town, S	tate, Zip (Code)
ž ş	11th a 27 is 27 is r trau		Nolan French - Husband		7734	Washingt	on Blvd.	#53 Elkri	don M	0 21	075
ē, -	f Healitem		20a. Method of Disposition	COL	ace of Dispos	ition (Name of atory or other place		Date 20	c. Location - C	ity or Tov	vn, State
9	at: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	ite	-	matory	1	31, 06 B	Itimae	o M	D
altimore,	perint. Tages I said and Mental Highen. International content and the said and the		21. Signatur of Funeral Service Lice See	1,00			ss of Facility	S. W1	1 -	-	
ä	Page 1		WWW XIChlan	nach	/ 29	emation 9 Baltim	Society of	of Marylar land 2122	id, Inc	•	
· .			23a. Part . Enter the disease, or complications that cau shock, or heart failure. List only one cause of parts.	sed the death.	Do not ente	r the mode of dyir	ng, such as cardiac	or respiratory arrest	1		Approximate Interval Between
P	hysician		Immediate Caudition	C. UT	EI	M 400	ARDI	AL INF,	ARCT		
	/Medical										
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Ax.	nd ransi	Examine	that initiated events) (IT!		67	ME	LL11	0.5		
0	en ar en ar irial-t		resulting in death) Last Due to (or	as a conseque	ence of):						
. Box 68760, 🔨	physiclen and the burial-transit	dlcal	d								
39	ing pl	Med	IF FEMALE:								
Вох	ttend or usi	an/	23b. Was decedent pregnant 1 Live birth	n 2 ☐ Fetaf ∈	death 3 🗆	Ectopic pregnanc	у		23d. Date Mont		ry Day Year
0	the a	Physician/Me	1 ☐ Yes No 4 ☐ Pregnan 9 ☐ Unknown 9 ☐ Unknown	t at time of dea n	ath 5∟	Other (specify) _					
<u>G</u>	requires that the beauticenting about the attending a hould be detached for use as		Part fl. Dther significant conditions contributing to deal	h but not resul	lting in the un	derlying cause giv	ven in Part I	23e. Did tobac	co use contrib	oute to the	e cause of death?
S,	5 6	by	Taken build significant contactions contacting to com-			acity ing saudo gr		1 ☐ Yes	11		ably 4 □Unknown
Records,	been si	Completed							/ _		
0	2 s	nple						24a. Was an autopsy performe	pri	ere autop or to con ath?	osy findings available appletion of cause of
_ '	ate pag	Cor						1 ☐ Yes 2 €		Yes	2 No
Vital	rnysician: in this certificate rai director, pag	Be	25. Was case referred to medical examiner? Hospitaf:			l Ott	205	h (Check only one)			
o d	this c	2	1 1 105 2 12 140 1 1 mp		R/Outpatien 28b. Time of	3 DOA	4 Nursing Ho	ome 5 Residence 28d. Describe how)
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Sic	Attending ir death. ector: After by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Pface of	Injuny - At hor	me farm str	eet, factory, office	, 100 2	28f. Location (Street	et and Number	or Rural	l Route Number
	or A after Direction by	Certification:	4 Homicide determined 200. Place of building	, etc. (Specify))	ot, ractory, omco		City or Town,			
_ }	To the Hospital of Attenting within 2 4 hours attended the Tothe Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Physician: To the b	est of my know	vledge, death	occurred at the tr	me, date and place.	and due to the cau	se(s) and man	ner as sta	ated.
	24 h 24 h Fur etely	edical	(Check only 2 Medical Examiner: On the bas	is of examinati							
:	vithin Fo th	Me	29b. Signature and title of certifier	-		29c. Licens	se number	290	. Date signed	(Month, L	Day, Year)
	->-0		I from Wha	/	(\cdot)))	00 63	1141	7/	31/	06
•	/		30. Name and address of person who completed cause	of death (Item	23a) (Type,	Print)		1	0	^	
	9		ARVIND DESKI	115	K	ESCE	KRD	YLE	N DI	14	NIGMD
Angel Application	St	ate		strar's Signat	ure	-		/			
	Regist	rar	AUG 0 2 2006	was l	K AND	SALL!					

State of Maryland / Department of Health and Mental Hygiene 2 1 1 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Gertrude Elizabeth Grunder Ju1y 4:10 P. M 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number, Examiner Linthicum Anne Arundel 210 Coronet Drive 8. Date of Birth (Month, Day, Year, July 24, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7 Age (In vrs. last birthday) **Funeral** Min Months Days Hours 1 □ M 2 🕅 E 93 216 36 3516 Ĩ913 Maryland Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Anne Arundel Linthicum Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S. 210 Coronet Drive 21090 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 I No Specify: Specify: White ģ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bank Teller Banking 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be finance of the marked of Joseph Nelligan Mary Foster ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) is 1 and 2 s of Health an item 27 is Lynda Koch / Daughter 210 Coronet Drive Linthicum, Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Depertment of He
Important: If iten
eny injury or oth 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/28/2006 Baltimore, Maryland New Cathedral Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Lice 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Heute **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physicien and as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical ettending p IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ţ 4 Pregnant at time of death 5 Other (specify) signed by the e o 9 Unknown 9 I Unknown ئە Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4. Unknown been signated 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas autopsy performed 2 No certificate 2 No 1 ☐ Yes 1 ☐ Yes Division of Vital Attending Physician: Be 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DDA Other: 4 Nursing Home 5 Fesidence 6 Other (Specify) 2 1 Yes 2 No his 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 ☐ Accident within 24 hours efter death To the Funerel Director: completely filled in by the 6 Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 055506 170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roltinge Maryland 21225 3721 Poter Street er tren MA 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

AUG 0 2 2006

State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LONG-GREEN BALTIMORE GENESIS If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Jan 2 1910 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ ▼F 216-01-9793 96 Yrs. Director MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits worde I in then "neturel", or items 23a or 28a-f ehor the Medical Examiner must be notified at Md No 2 No **Funeral Director** Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 Melrose Avenue 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other then "neturel", or ite other traumatic event, the Medical Examina 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify:white ۾ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) 12 College (1-4or 5+) administrative assistant clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Gibson Sue Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 articles of the strain of Health ar βeverly J. Kram (guardian) 10519 Marriottsville Rd., Randallstown, Md 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Depertment of important: If It is eny injury or or 1 □ Buriat 2 □ Cremation 3 □ Removal from State Woodlawn Cemetery 4 □Donation 5 □ Other (Specify) 8-2-06 Baltimore, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee ▶ Parge Spiright Sperbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) this certificate has been signed by the earl director, page 2 should be deteched? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 1 ☐ Yes 1 Yes 2∏ No 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Other: 4 Dursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No М investigation Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who 31. Date fited (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 _ State	State of Marylar	•	ent of Heal			[()	06	21	82
			Ragistrar 1. Decedent's Name (First, Middle, Last)		Octimos	ale of Dea	207	2. Date of Dea	Reg. No. ath		3. Time of De)eath
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	/Medic Examin		4a. Facility Name (If not institution, give str	reet and number)		ty, Town, or Loca	ation of Death	7	4c. County of	of Death	1000	
			GILCHRIST	HOSPIC	E	BA.	LTIM	ORE		N	IA	
	Funeral Director		5. Social Security Number 6. Sex 1246 - 48 - 9 / 90 125 1	7. Age (In yrs.	A Yrs. If Und Month		Inder 24 Hrs. ours Min.	8. Date of Birt (Month, Date MAY 20	, 1934	9. Birthp Cour NOR	place (State or Forty) TH CARD	Foreign
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	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mentai Hygiene. If Health and Mentai Hygiene if Health are 1 te marked other then "neturel", or Items 23a or 28a-f ehow other traumatic event, the Medical Examiner must be notified at	ctor	MARYLAND N/	A		BAL	LTIM	ORE	CITY		1X Yes 2	2 🗆 No
	with th	Directo	10e. Styleet and Number		10f. :	Zip Code	1, 21	21.	10g. Citizen of W	hat Cour	itry?	
	eath v	Funeral	6601 N. CH	2. Was Decedent Ever in U	I KEET	cedent of Hispan	ic Origin? (Spe	ocity Yes or No		- Americ	can Indian.	
	ther d	Fun	11. Marital Status 12 1 □ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		cedent of Hispan pecify Cuban, Me		Rican, etc.)	Black	, White,		
Maryland 21215-0036	within 72 hours after ane. then "neturel", or Ite the Medical Exemina	Ď	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 🗆 Yes	2,83,No Sp	ecify:		Specify:	BL	ACK	_
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ano	d be antal	To Be	ROLLAND	GILA	MRF S	5R. 1-	-1171	ARFT	H	51	41714	
<u> </u>	should nd Mer marke umatic	-	19a. Informant's Name/Relationship (Type		19b. Mailing Addre	ess (Street and N	lumber or Rura	I Route Numbe	er, City or Town, S	State, Zip	Code)	
	and 2 ealth a n 27 le		DOROTHY GILMORE	E (WIFE)	2504	S. E.	MERSO	ON 5T.	BALTO	0.1	10,215	223
Baltimore.			20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Rea		Place of Disposition (fi cemetery, crematory of			ate	20c. Location - 0	City or To		
<u> </u>	nit. Pages artment of i ortant: If Its Injury or o		4 Donation 5 Other (Specify)	M	T, ZION	CEMETER	V.08-0	15-06	LANSD	OWN	E, M	D.
alt	permit. Page Department of Important: If eny Injury or		21. Signature of Funeral Service Licensee	(da)	22. Name	and Address	Facility 3	Rawn	JR. FO	INE	RAL HO	OME
ш	20E = 9			im	279	ON. 1	-4478	NAVE	,,,	0,1		
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	ations that caused the dea cause on each line.	ith. Do not enter the m	rode of dying, sur	ch as cardiac o	r respiratory ar	rest,		Approximate Interval Betwe Onset and Dea	een
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5	/Medical Examiner			Due to (or as a conse	quence of):	110	/ c \.n	techn	_		-1015	
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8760	ate be executed the burial-transit	dical	d.									
= 0	n certifica anding ph use as th	Med	IF FEMALE:	STRW						1		
Pox	eath certif attending for use as	lan/	23b. Was decedent pregnant in the past 12 months?	 c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 	el death 3 □Ectopio	pregnancy			23d. Date Mon		ery Day Yea	ar
o.	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	death 5 Other	(specify)						
ر م	that the de ed by the detached	P.	Part II. Other significant conditions contri	ributing to death but not re	sulting in the underlyin	g cause given in	Part I.	23e. Did to	obacco use contri	bute to th	ne cause of dea	ath?
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al Records.	w requir been s should	Completed						24a. Was	an 24b. W	ere auto	psy findings av	vailable
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	ng Ph Iter th	ä	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?			now injury occurre			
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Division of Vital Records.	al or Attending Physician: effer death. I Director: After this certified d in by the funeral director; I	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, street, fac hify)	tory, office	1	28f. Location (S City or Tox	Street and Numbe vn, State)	r or Rura	J Route Numbe	ar,
	spita ours serel		(Check only 2 Medical Examine	cian: To the best of my kr er: On the basis of examin	owledge, death occurr	ed at the time, da	ate and place, a	and due to the	cause(s) and mar	ner as si	tated.	
	To the Hos within 24 h To the Fur completely	Medical	29b. Signature and title of certifier	and manner stated.		29c. License nun			29d. Date signed			
	7 × 100	-	Marin	N		058	503		July 3			
	3		30. Name and address of person who com	inleted cause of death //tr	am 23a) /Type Print	D58			رانان			
_	2		AARON Chirles	ins 6601 v	1. Charles	ST BA	more	ono	26207			
	Sta Regist	ate rar	31. Date filed (Month, Đāy, ¥ear) →	32. Registrar's Sign	nature	W-						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July **Physician** $\overset{\text{Day}}{26}$, 2006 Chhaya Gupta 9:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Villa Nursing Center Baltimore Catonsville 8. Date of Birth (Month, Day, Year)
May 15, 1924 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F Months Min. Hours 213-17-6359 82 Yrs. Director India Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location ir than "naturel", or Iteme 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland | Prince George's Laurel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 14648 Cambridge Circle 20707 India Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, e filed within 72 hours after dal Hygiene. 1 ☐ Yes 2 ☐ X\o If Yes, Give Year or Dates: 1 Never Married 2 Married 10. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify Asian Indian ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home . Pages 1 and 2 should be filed w tment of Health and Mental Hygier tent: if item 27 is marked other it jury or other treumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ravati Prasad Champa Devi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anil Gupta, Son 14648 Cambridge Circle Laurel, Maryland 29707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Dependent Important: If any injury of once. 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 07/28/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor ²Macnabo Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician BRONCHO-PNEUMONIA Three days /Medical Due to (or as a consequence of) Examiner ALZHEIMER'S DISEASE year Sequentially list conditions, I any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a gonsequence of Examine death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ HYPOTHYROIDISM 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ARTERY DISEASE CORDNARY 1 ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No ဥ To the Hospitel or Attending Phys within 24 hours after death.
To the Funerel Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 27, D.30469 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARKWAY # 308, COLUMBIA : MO.21045. NB VELLANKI, 8850, COLUMBIA 100 31. Date filed (Month, Day, Year) 32 Degistrar's Signature State AUG 0 2 2006 Registrar

			For Amend #5 Per FIFStees of Sympology / Repartment of Health and M 1 - State Registrar Certificate of Death	ental Hygie Rag		24184
			1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day V	3. Time of Death
	Physici		Genevieve Frances Gorsuch	Month 2	Day Year	7:400 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. Ciby Town, or Location of Death	0, 0	4c County of Death	, , , ,
	Examin	ei	Franklin Square Hospital Kosedale		Baltin	iore
	Funeral		Months Days Hours Min.	8. Date of Birth Sept.	9. Birthp	lace (State or Foreign try)
	Director		212 20 0302	sept. /	, 1745	MD
	pue *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1	Od. Inside City Limits
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3	ith to	ä	10e. Street and Number 2510 T.iberty Parkway 21222	109	. Citizen of What Cour USA	try (
(D)	deeth with the Maryland me 23s or 28s-f show f must be notified at	Funeral Director	2516 215616, 151616,			
. =	er de	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spell of Yes, specify Cuban, Mexican, Puent of the Specific Cuban, Puent of the Specific	city Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36 ≥	s aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: ③☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: Whi	te
6	hour	D	3/L Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	16	b. Kind of Business/Inc	h.at
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Jen IV ie VE 1215-0036	within ene. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Secretary		Bethlehen	Stee1
200	Hygir ther		17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Ma	iden Sumame)	
au au	s I and 2 should be filed within 72 hours after deeth with the Marylan Hoglene. Fleath and Mantal Hyglene. Item 27 is marked other than "natural", or Iteme 23a or 28a-1 ehow other treumatic event, the Medical Examinar must be notified at	Be	Table 7 sheld b	a Pavuc		
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) 6, I	of Health liem 27 other tr		14011010 271	-	c. Location - City or To	
7) 2			1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Monday or other place)			
Ō. <u>H</u>	E 48 2				lkridge,	
Salt (Depentit. Depentitmont Import eny inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bra			
<u> </u>	⊕ □ ≒ ● Ø		PA, 2134 Willow			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	r respiratory arrest	•	Approximate Interval Between Onset and Death
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	/Medical		resulting in death) Due to (or as a consequence of):			
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7 5	w requires to been signer should be a	Pa	VRE JOSIS	1 X Yes	2 □ No 3 □ Prob	ably 4 □Unknown
E / JAK). Records,	s bee	ojet	'	24a. Was an	24b. Were auto	psy findings available inpletion of cause of
Re Co	The lav	E		autopsy performe	d? death?	28 No
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120	ding Phy h. After this funeral c		27. Manner of Chath 28a. ate of Injury 28b. Time of 28c. Injury at 2	28d. Describe how		<u>, </u>
- uo	ding th.	Ş	↑ Natural 5 Pending (Month, Day Year) Injury Work? Accident investigation M 1 Yes 2 No			
15:12	r Attender designations of the color:	fice	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm, street, factory, office	28f. Location (Stree	et and Number or Rura	l Route Number,
原首	effe Dire	Certification:	4 Homicide building, etc. (Specify)	City or Town, S	State)	
111	To the Hospital or Attending Physician: within 24 hours effer death. To the Funarel Director: After this certified completely filled in by the funeral director, it	aic	29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the caus	se(s) and manner as s	ated.
1	24 h	edicai	(Check only Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurrence) and manner stated.	ed at the time, date	and place, and due to	the cause(s)
	ormpl	Me	29b. Signature and title of certifier 29c. License number	29d	. Date signed (Month,	Day, Year)
	->= 0		VASTED, KOS MA	0	7/28/0	Br
	/		30, Name and address of person who completed cause of death (Item 23a) (Type, Print)		+ -/-	
	5		Dr. Adedovin Akintide 9000 Franklin Su. Driv	e Baltir	noce md	21237
	St	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature	<u></u>	1110	
	Regist		AUG 0 2 2006			

			1 - For State Registrar	State of Mary	land / Depa <i>Cei</i>	artmei <i>rtifica</i>	nt of He <i>te of E</i>	ealth and <i>Death</i>	i Men		iene) (006	24185
5	Physic /Medi		Decedent's Name (First, Middle, Last Mary)	Hill					Date of Deat Month	Day	Year 2006	3. Time of Death 5:35 P M
	Examir Funeral		4a. Facility Name (If not institution, give ST A G N ES H OS 5. Social Security Number 6. Se 215–22–6055	X 7. Age (In	yrs. last birthday)	B	ALTI er 1 Year	Location of De NOR If Under 24 H Hours Mi	rs. 8. [Date of Birth Month, Day,	Year)	nty of Death NA 9. Birthp	**
9	≥ Director		Usual Residence of Decedent		93					12-08-	12		N.J.
	Maryia fishov	jo	10a. State 10b. County N.		c.City,Town or Lo Balti							1	0d. Inside City Limits 1X Yes 2 □ No
	with the	Director	10e. Street and Number 8122 Elizabeth Ro		10010		Code 2112	2		1	-	of What Coun	ntry?
036	72 hours after death with the Maryland 'natural', or Items 23a or 28a-1 show diest Exeminat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married MUWidowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:	ř	Was Dece If Yes, spe 1 \(\text{Yes} \)	edent of His ecify Cuban	spanic Origin? , Mexican, Pud Specify:	(Specify erto Rica	Yes or No- n, etc.)	14. F	Race - Americ Black, White,	
Maryland 21215-0036	within ane. than	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 10th grade	cation le completed) College (1-4or 5+)		dent's Usi kind of w DO NOT L eamst	ork done du use retired)	tion uring most of w	vorking			Business/Inc	
land		To Be	17. Father's Name (First, Middle, Last) Albert		Smith			18. Molher's N Genev		st, Middle, A		ame) Gross	
Mary	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (T) Delilah Washingto					nd Number or I					Code) i 63303
Baltimore,	of H		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	Ob. Place of Dispo cemetery, cren Glen Hav	sition (Na matory or	me of other place	,	Date -3-06	2	20c. Locatio	n - City or To Burnie	wn, State
Balti	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licens	o Wan			nd Address	of Facility East	1:			e, Md. h Ave.	21202
April 2	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or composhock, or heart failure. List only of the state of the st	ilications that caused the ne cause on each line. a	CRANT	er the mod		, such as cardi					Approximate Inlerval Between Onset and Death
(68/60,	ing physician and as the burial-transit	Medical Examiner	resulting in death) Last	Due to (or as a co									
P.O. Box	The law requires that the death certif tie has been signed by the attending tage 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2☑No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic p Other (s						Date of deliver Month	ry Day Year
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Division of Vital Records,	w u	e Completed	Of Warrant American							24a. Was ar autopsy perform I □ Yes √2	ed?	death?	osy findings available npletion of cause of 2 No
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DIVIS	To the Hospital or Attending Physician: within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (St	At home, farm, stre	eet, factor	y, office		28f. L	ocation (Str. City or Town,	eet and Nur State)	mber or Rural	Route Number,
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)		Med	29b. Signature and title of certifier	and manner stated.	D		c. License	number	,			ned (Month, D	
	3		30. Name and address of person who co PRIYANKA NELL	ompleted cause of death	(Item 23a) (Type, I	Print)	AVE	NUE,	BF	WIL	NOP	E M)-21229
**	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 2	2006 32. Regis rar's S	Signature	does	W.					-	•

			1 - For State Registrar	Sta	ate of	Marylan		artmen <i>tificat</i>				lental Hy	giene	006	24	186
	Physici		1. Decedent's Name (First, Middle		arl D	enver	Handsc	humac	her			2. Date of D Month July	Day 30	2006	3. Time of 12:15	
	/Medic Examin		4a. Facility Name (If not institution	, give street	and numb	er)		4b. City,	Town, or	Location	of Death	July	1	nty of Death		
	LXMIIII		Gilchrist Ho					Ва	altin	nore			Bal	ltimor	·e	
	Funeral		5. Social Security Number	6. Sex	7.	Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth		place (State or	Foreign
	Director		235 40 6726	1 ∑ M :	2LJ F	80	Yrs.	MOTITIES	Days	riours	IVIIII.	May 14		Wes	t Virgi	nia
	and w		Usual Residence of Decedent 10a. State 10b. County			10c. Cit	y, Town or Lo	cation							10d. Inside Cit	v l imits
	Maryli f • ho	5		/A			Baltimo								1 X Yes	•
	28a-	Director	10e. Street and Number					10f. Zip	Code				10g. Citizen o	of What Cou	ntry?	
	3a or	0	1002 Druidor	Cour	t				212	25			U.S	3.	,	
	death	Funeral	11. Marital Status	12. W	as Decede	ent Ever in U. as? No	.S. 13. \	Was Deced	dent of Hi	spanic Ori	gin? (Sp	ecify Yes or N Rican, etc.)	o- 14. R	ace - Amen		
9	72 hours after death with the Maryland "netural", or Items 23a or 28a-f ehow velical Exama art must be collined at	E.	1 Never Married 2 Marr		☐ Yes 2 Yes, Give	No No		1 🗌 Yes		Specify:		Tiloati, etc.)		lack, White, cify: Whi		
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212	within jene.	Completed	Elementary/Secondary (0-12) 6th	C	ollege (1-4	or 5+)		Work		,			Daviso	on Che	mical	
9	e filec al Hyg othe vent,	Bec	17. Father's Name (First, Middle,										, Maiden Sum	ame)		
ylaı	12 should be filed within and Mental Hygiene. 7 le marked other than "Ireumatic event, the Mad	To E				macher						Stewar				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 ie marked other than any injury or other treumatic event, the Magnes.		19a. Informant's Name/Relations Charlene Vest				19b. Mailin						e, Mary			
J.	of Hee		20a. Method of Disposition	- 00		1 0	lace of Dispo emetery, cren	sition (Nan	ne of ther place	9)		Date	20c. Location	n - City or To	own, State	
Ë	Page nent c ant: If ury or		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		al from Sta	3.16	dar Hil	-			3/2/2	2006	Baltim	ore, l	Marylar	nd
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	70 E # 9		NIWI	We	m	degle							timore,	Mary		
-			shock, or heart failure. List only one cause on each line."										Approximate Interval Betw Onset and D	reen		
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<i>'</i> 2', ■	D V≡	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	J b. —	Due to (or	as a conseq	uence of):		110		()			7	
70	cate be executed by sician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Dura to Jac											
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687	certificate be Iding physicia Ise as the bur	adic		d												
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000	law require as been si 2 should t	iete				- · · · · · · · · · · · · · · · · · · ·						24a. Was	an 24h	. Were auto	nsv findings a	vailable
SQUAMCARES () Division of Vital Record	Physician: The lav this certificate hes al director, page 2 :	Completed										auto perfe	psy ormed? 2 2 No	prior to co death? 1 Yes	psy findings a mpletion of ca 2 No	use of
<u> </u>	ian: artifica ctor, p	ВеС	25. Was case referred to medical examiner?							26. Place	of Death	(Check only				
25	Physician: this certific ral director,	2	1 Yes 2 No	Hospit	1 🗀 Inp		ER/Outpatien		Othe	or: 4□ Nu	rsing Ho	me 5□Res	dence 6 🖯 O	ther (Specif	n Cton	u ce
₹ S us	tending P eath. or: After t the funera	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pendin		a. Date of I (Month,	njury Day Year)	28b. Time of Injury		8c. Injury Work	at ?			how injury occi			
isic	death ctor: y the	ficat	2 Accident investig	not be	e. Place of	Injury - At ho	ome, farm, stre	M ent factors		∕es 2⊡		28f Location /	Street and Nun	nher or Rurs	al Boute Numb	or
カウシ信仰AmのCHC Division of Vital R	s after al Dire	Certification:	4 Homicide determ	ined	building	etc. (Specif)	<i>(</i>)	oot, radiony	, 011100			City or To	wn, State)	100, 0, 110,0	11 710016 140110	G,
ANT	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifyir (Check only one)	Examiner: (To the be on the basi	s of examina	wledge, death tion and/or inv	occurred restigation,	at the tim , in my op	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s) and r date and place	manner as s e, and due to	tated. the cause(s)	
	within 2 To the comple	Mec	29b. Signature and title of certifie	/	10	Juneau.		/	License				29d. Date sign	ned (Month,	Day, Year)	
	, _		My frist	ruy 1	nx	gor	an			520			Augu	s7 (, 200.	
	10		30. Name and address of person	whorcomplet	ted cause	death (Item	23а) (Туре,	Print)		, (6	e 0.	b. and	· ~	N	
	4		31. Date filed (Month, Day, Year)	(6 (4	7 (istrar's Signa		CUL	art	00 J		·soli	o, and	(- CIE	
	Sta Registr		11 0 1 2 200	6	32. Heg		book	1								

		•	1 - For State Registrar	State of Maryla	-	artment of F			ene 2 0 0 8	24187
	Physici	an	1. Decedent's Name (First, Middle, Last	")				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Harriett	<u>C.</u>	Hou			July	27 2006	1100
1	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deat		4c. County of Dea	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In)	rs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	Washi 9. Bir	thplace (State or Foreign ountry)
l.	Director		214-09-5238	M 2 4 F	941 Yrs.	Months Days	Hours Min.	Sept 30	3 1911	MD MD
	pu .		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	ocation		•		10d. Inside City Limits
	Maryla f eho	ō	1 2 2 2 2		17	i				1 4765 2 No
	the h	Funeral Director	10e. Street and Number	ington	1100	10f. Zip Code	Y 1	10	g. Citizen of What Co	ountry?
	h with		16909 Alcot	+ Rd			21740		US	A
	deat	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of I If Yes, specify Cub		pecify Yes or No-	14. Race - Ame Black, Whi	erican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene important: If item 27 is marked other than "neturel", or Iteme 23a or 28e-f ehow air Injury or other traumatic event, I'm Medical Examinar must be notified at ance.	by Fu	1 Never Married 2 Married 3 Midowed 4 Divorced	1 Yes 2 Tho		1 □ Yes 2 🗗 No		,	Specify:) '1
5-0036	ture!	ed b	15. Decedent's Edi	Year or Dates:	16a Dece	dent's Usual Occup	nation		16b. Kind of Business	Inte
215	n n	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done DO NOT use retire	during most of wo	rking		,
212	d with giene er the	E	Elementary/Secondary (0-12)	College (1-401 3+)	Fa	ctory 1	Worker		Shoe	
	be file	Be	17. Father's Name (First, Middle, Last)	. 1	,	/	18. Mother's Na	ne (First, Middle, M	faiden Sumame)	
<u>X</u>	should the should the	P	Charles	Hamon			Leon		Fenburge	
Maryland	12 sh h and 7 is rr traum		19a. Informant's Name/Relationship (T	1 /2 11	100 V 100 M	ANS 1923	11 01	1 1 1 1 1 1 1 1 1	City or Town, State,	S
	1 and Health Iom 27		20a. Method of Disposition	d Course daish	b. Place of Dispo	sition (Name of	iott Rid	Date	20c. Location - City or	
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m	Depermi Depe impo eny la		1 Sems	1//	1 1	EAM 123	a midual	lar Dr	Jessup, P.	A 18434
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	/Medical Examiner		resulting in death)	Due to (or as a cons)	0				
Ш	Examiner	7	Sequentially list conditions, if any, leading to immediate	b. Supsus						
	uted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	Deline	tion					
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89)	Physician: The law requires that the death certificate be executed this certificate hes been signed by the attending physicien and rall director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:		v'					
Box 6	attend attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	Ectopic pregnanc	у		23d. Date of de Month	livery Day Year
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o.	ures thet the death certific signed by the attending p d be detached for use as:	by Pr	Part II. Other significant conditions co	ontributing to death but not	resulting in the u	inderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
rds	w requires been sig should b	ed b	Olmetra					1 □ Ye	s 2 No 3 P	robably 4 Unknown
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Œ	The ete h	Completed	0	0				perform	ned? death?	
Division of Vital Records,	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		04	100	ath (Check only one		
of	Physical direction	- To	1 Yes 2 No 27. Manner of Death	1 Lerinpatient 2	2 ER/Outpatie	II JUDA		lome 5 ☐ Reside	nce 6 Other (Spe	ecify)
o	ding th: After fune	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year	r) Injury	Wo	rk?]Yes 2 □No	200. 20001100 110	W mjury cocurred	
/isi	Atten r deal actor by the	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - A	At home, farm, st	reet, factory, office		28f. Location (Str	reet and Number or R	ural Route Number,
ā	s afte s afte of Dir	Certification;	4 _ FIORICIDE	building, etc. (Sp.	өспу)			City or Town	, State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai ((Check only 2 Medical Exam	ysician: To the best of my liner: On the basis of exam	knowledge, deat	h occurred at the ti	me, date and place	e, and due to the ca	use(s) and manner a	s stated.
	the hin 24 the F	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen:			9d. Date signed (Mon	
	L X L S		290. Signature and title of telling			230. 2001.				
			30. Name and address of person who d	completed cause of death /	Item 23a) (Type	Print)	62223	>	7-28	- 06
			Dr. Bolarum	340 M	il SI	Hon	· Wd.	71746		
-	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si		1				
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	/Medic		4a. Facility Name (If not institution		a Vi		4b. City, To	own, or L	ocation of D	JVL.		c. County of De	
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	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2X F	7. Age (In yrs. 62	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hours N	Min. (Monti	n, Day, Yea		irthplace (State or Foreign Country)
46	Director		216-42-7851 Usual Residence of Decedent			175.				Marcl	1 31 ,	1944 Ma	ryland
	yland how		10a. State 10b. Count	у	10c. C	ity, Town or Lo	cation						10d. Inside City Limits
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	with the	Dire	10e. Street and Number 4411 Adelle Te	rrago			10f. Zip C				10g. (Citizen of What (Country?
	na 23	Funeral Directo	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.		1229 nt of Hisp		? (Specify Yes o	or No-	USA 14. Race - Am	
9	72 hours after death with the Maryland natural', or Itama 23a or 28a-f show alsal Examinet must be notified at		1 XNever Married 2 ☐ Ma	rned 1 Tes	2 X No		fYes, specif 1 □ Yes 25		Mexican, P	uerto Rican, etc	.)	Black, Wh	
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yla	2 should b and Menta Is marked raumatic e	ပ္	Hollen	Busey	He	offman							eth Zies
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylar at of Health and Mental Hygiene. If Itam 27 is marked other than "natural", or Itama 23e or 28e-f show or other traumatic event, the Medical Examirer must be notified at		19a. Informant's Name/Relation	9395-031	2.8	1853000	200					or Town, State,	Zip Code)
	permit. Pages 1 and 2. Department of Health a Important: If Itam 27 is any injury or other trau QDCs.		Margaret E. Ro 20a. Method of Disposition		20b.	Place of Dispo	KOD3 I	of	Balti	Date N		207 Location - City o	r Town, State
E C	Page: nent o int: If		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (State Ba	Place of Dispo cometery, crei Itimore Loudon	Crema	itory	y 7/	31/06	Ва	ltimore	, Maryland
Baltimore,	permit. Departri Importa any inju		21. Signature of Funeral Service	e Liberson		22	2. Name and	Address	of Facility		Park	Funeral	Home
	20 E # 9											, MD 21	
	Physician /Medical Examiner		23a. P. H. Enter the disease, cook, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	caused the deal apach line.	ance	er the mode	of dying,	such as can	diac or respirato	ory arrest,		Approximate Interval Between Onset and Death
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	w requires that s been signed b should be deta	by	Part II. Other significant condit	ions contributing to d	eath but not res	sulting in the u	nderlying cau	se given	in Part I.		Did tobacco	V/	to the cause of death? Probably 4 □Unknown
Division of Vital Records,		Completed								- : :	Was an autopsy performed?	prior to death?	
VIE	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		75000		Other:		Death (Check o		Acres 10	Sisters
ion of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	atlon: To	27. Manner of Death Natural 5 Pendi 2 Accident invest	ing 28a. Date (Montigation		ER/Outpatier 28b. Time of Injury		: Injury a Work?	4 🗀 Nursin			6 Other (Sp jury occurred	HOUSE -
Divis	ital or Atturs after de ral Director	Certification:	4 🗆 Homicide	mined 286. Place build	of Injury · At hing, etc. (Speci	(fy)				City o	r Town, Sta	ite)	Rural Route Number,
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_	10		Vaul Gar	who completed day	of death (Ite)	g 23a) (Type,	Print) ALL		13a1	timer	e M	nd z	2006
	Sta Registr		31. Date filed (Month, Day, Year AUG 0 % 20	32. 5	Registrar's Sign	ature							

	2		1 - For State Registrar										
		_	- Hegistrar			Cei	tificate of	Death		Reg. N	<u>.</u>	5 24 89	
	Physicia	an	1. Decedent's Name (First, Middle, Linda Irene Ha						2. Date of Month		ay Year	3. Time of Death	
	/Medic	al	4a. Facility Name (If not institution,				4b. City, Town, o	r Location of F	07	2	5 200 c. County of Dea		
1	Examin	er	Holy Cross Ho				Silver				ontgom		
	Funeral		5. Social Security Number 6	. Sex 7. Ag	e (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24				rthplace (State or Foreign country)	
	Director		043-50-5310	1□ M 2[XF		51 Yrs.	Day o	110010		/18/		nnecticut	
land	Mo M		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits	
Man	fled	tor	MD Prince	George	Sui	tland	Ē				1 No 2 No		
th th	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. C	itizen of What C	ountry?	
aath w	8 23a	erai	3394 Curtis D		Fuer in 11.6	12.1	20746	ii- O-i-i-	2 (Canada Van es	US		odoso lodica	
fler d	rkem	Fun	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 Yes 2 X			Was Decedent of H f Yes, specify Cuba	in, Mexican, F	Puerto Rican, etc.)	NO-	14. Race - Am Black, Wh	ite, etc.	
036 ours a	0 4	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🔀 No	Specify:			Specify:	Black	
1215-0036 within 72 hours after death with the Maryland	natu	Completed by Funeral Director	15. Decedent's (Specify only highest	Education grade completed)		(Give	ient's Usual Occup kind of work done	durina most of	f working	16b.	Kind of Busines:	s/Industry	
21215-0036 of within 72 hours aft	6 th	duic	Elementary/Secondary (0-12) 12th	College (1-4or 5	5+)		oo NOT use retired eacher	"		Chi	ristia	n Education	
کا کا	other vent,	BeC	17. Father's Name (First, Middle, La	st)	1				Name (First, Mid				
Maryland	Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "naturel", or items 23a or 28a-f ehow any injury or other treumatic event, the Medical Examinar must be notified at once.	To	Nathaniel Roc						Rodgers				
Mar	h and 7 le m		19a. Informant's Name/Relationship Justice Hardy				g Address <i>(Street)</i> Curtis					Zip Code) 20746	
e -	Healt tem 2 other		20a. Method of Disposition	/ Husband	20b. Pl		sition (Name of natory or other place		Date	-	ocation - City o		
Baltimore,	int: If i		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		1		natory or other plac Iill Cem		7/29/06	Su	itland	l. MD	
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			23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that caused by one cause on each lin	i the death ne.	. Do not ente	er the mode of dyin	g, such as car	rdiac or respirator	y arrest,		Approximate Interval Between Onset and Death	
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687	g phys			d									
Box 68	endine r use a	M/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy				23d. Date of de	alivery	
(C) (E) (E) (E) (E) (E) (E) (E) (E) (E) (E	been signed by the ettending ph	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown			Other (specify)			-	Month	Day Year	
OL ₫	ed by detacl	, Ph	Part II. Other significant condition	s contributing to death b	ut not resu	lting in the ur	nderlving cause give	en in Part I.	23e. D	id tobacco	use contribute (o the cause of death?	
Vital Records,	n sign	d by								☐ Yes 2		robably 4 Unknown	
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E E	ate ha	Completed							pe	itopsy erformed? s 2∑√N	death?	completion of cause of s 2 XNo	
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vision of Vita	this c ral din	2	1 ☐ Yes 2 XNo 27. Manner of Death	Hospital: 1 Mapatie 28a. Date of Injur		ER/Outpatien	t 3□ DOA Othi	er: 4 ☐ Nursii	ng Home 5 □ R 28d. Descril			ecify)	
Division of	th. : After s fune	Certification:	1 Matural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da)	y Year)	Injury	Worl	Yes 2∐No		oe now inju	ary occurred		
Visi	ector by the	tifica	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At hor	me, farm, stre	eet, factory, office	30014		n (Street a Town, Stat		ural Route Number,	
	rs after all Dir	Cert											
Di Hospital or	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical Exponent	Physician: To the best of aminer: On the basis of	of my knov f examinati	vledge, death ion and/or inv	occurred at the ting restigation, in my of	ne, date and p pinion, death o	place, and due to to occurred at the tin	he cause(: ne, date an	s) and manner a lid place, and du	s stated. e to the cause(s)	
To the	vithin o the omple	Мес	29b. Signature and title of certifier	and manner sta	2180.		29c. License				ate signed (Mon		
•	- > F 0		15/2	X ms	\sim		D625	71		C	7/25/0	6	
	6		30. Name and address of person will Bromerand,		_	23а) (Туре,	Print)	<u> </u>		<u> </u>			
	Sta Registr		31. Date filed (Month, Day, Year) AUG (2)	32. Remistra	ar's Signat	ure	land.						

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Hoy **Physician** 30 PM trude 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HOPKINS Baltmore Bayview Lare Center n/a If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 3/10/26 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Yrs. 80 Director 212-20-0208 Usual Residence of Decedent Maryland filed within 72 hours after death with the Maryland 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23e or 28a-1 show the Medical Experiment wat be notified at 1 Yes 2 No Director Baltimore n/a Md 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21224 USA 3536 E. Fairmount Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Waitress Sip & Bite 10 othar t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hiant: If itam 27 is marked other George Mach Anna Golebiewska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 418 Imla Street Baltimore, Md. 21224 Dianna Billmyer / other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State pernit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus 7/31/06 Baltimore, Md. 21. Signature of Funeral Service Licenses Kaczorowski Facifyuneral Home P. A. 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, a complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Depatit Physician week disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** onsillar Carcinoma lears Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): been signed by the attending physician . should be detached for use as the مالاتك Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tracheox 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ 2 No 24a. Was an autopsy performed? disease 250No 1□ Yes 2√No or Attanding Phyaicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide within 24 hours a

To tha Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62177 2006 clor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bayview Circle Baltimore Hopkins Dawn Conklin 5505 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 2 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#19a, perfb, 2858, 8/3/06 TI

Amend Item 23a per dr., 6858, 08/07/06da b 24 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July **Physician** 22, 2006 Andrew H. Havre 5:17 p. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Co. Bel Air Birthplace (State or Foreign Country)
 Texas 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 1,1919 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min 461-03-6057 87 Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√XNo Director Maryland Harford Co. Bel Air 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 28 Huntington Place 21014 United States Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify. ğ White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Major 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Valdez Henry Havre Sarah 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. Carier/Daughter 28 Huntington Place Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Entombrent Dulaney Valley Mem. Gardens 7/28/2006 Timonium, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 5305 Harford Road Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Terminal Aspiration Due to (or as a consequence of)

Physician /Medical Examiner

or Attending Physician: The law requires that the deeth certificate be executed

After

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completely filled in by within 24 hours after To the Funerel Dire Hospital

Division of Vital Records, P.O. Box 68760

Funeral

Director

or 28a-f show

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permit. Pages 1 end 2 should be filed to Department of Health and Mental Hygie Important: If Item 27 is marked other till eny injury or other treumatic event, IIIs 2006.

the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Physician/Medical Exam þ Medical Certification:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	INSO	N'S D.	T SEA	SE
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of of 9 □ Unknown	al death 3 □Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions o	ontributing to death but not res	sulting in the underlying	g cause given in Part I.		accouse contribute to the cause of death? is 2.21No 3
				24a. Was ar autops perform 1 \sum Yes 2	y prior to completion of cause of death?
25. Was case referred to medical examiner?			26. Place of De	eath Check only one	9)
1 ☐ Yes 2/☐ No	Hospital: 1 ☐ Inpatient 2X]ER/Outpatient 3□ t	DOA Other: 4 Nursing	Home 5 Reside	nce 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work?	28d. Describe ho	w injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factorify)	ory, office	28f. Location (Str City or Town	reet and Number or Rural Route Number, , State)
29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my known of the basis of examination and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occ	ce, and due to the ca curred at the time, da	tuse(s) and manner as stated. ate and place, and due to the cause(s)
29b. Signature and title of certifier	.7	2	9c. License number	29	9d. Date signed (Month, Day, Year)
Jan Mo	In for,	> 1	D00580	76 5	044 24, 2006

State Registrar 31. Date filed (Month, Day, Year) AUG 0 2 2006

Dr. Gary Noronha 3110 Wyman Park Drive Baltimore Maryland 21211 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036	T	In Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Item 27 is marked other than "natural", or Item 20 in the Moultal Exercities once.	To Be Completed by Fu
Vital Records, P.O. Box 68760,	ician: The law requires that the death certificate be executed	certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical Examiner

		Pleas 1 - For State Registrar	* -		k Indelible Ink. E Department of Hea Certificate of De	lth and Me	ntal Hygi		24192
Physici /Medic		Decedent's Name (First, Middle, VALARIE VIRGI	NIA JACKSON				Date of Death Month	Day Year 27, 2006	3. Time of Death 5:37 P M
Examir Funeral Director		4a. Facility Name (If not institution, Good Sam Ari 7 5. Social Security Number 216–56–7229	tan Hosp	e (In yrs. last bi		Under 24 Hrs. 8	Date of Birth (Month, Day, 9-20-19	Year) Co	th thplace (State or Foreign puntry) RYLAND
aryland show	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow			9-20-15	7.)1 MA	10d. Inside City Limits
with the M 3a or 28a-f	i Director	MD N/A 10e. Street and Number 1419 VIDA DR.		BALT	10f. Zip Code 21207		10	og. Citizen of What Co USA	1 ∑Yes 2 □ No ountry?
be filed within 72 hours after death with the Maryland the Hygiene. I have a second of other than "natural", or items 23a or 28a-f show event, the Moulcal Exercitive matalities redilled at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:		13. Was Decedent of Hispan If Yes, specify Cuban, M	nic Origin? (Specr lexican, Puerto Ric pecify:	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	te, etc.
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5 P E P 2		19a. Informant's Name/Relationship VIKI HORNE (DA) 20a. Method of Disposition			. Mailing Address (Street and I 1419 VIDA DR. t Disposition (Name of		E, MARY	LAND 2120	7
permit. Pages 1 and 2 Department of Health important: If Item 27 is any njury or other tra		1 ☐ Burial 2 ☐ Fremation 3 4 ☐ Donation ☐ Other Cope	cify)	METRO	CREMATORY NER ² . Name and Address of	8-3-20 Facility PHIL	06 B		MARYLAND E, P.A.
Physician /Medical Examiner physician and physician and the priral-transit	dicai Examiner	23a. Part I Inter the disease, or or shock or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	the death. Do ne. I o Ne. a consequence a consequence consequence	not enter the mode of dying, su A R A A of): ETE H 6 of): EN SLOW				Approximate Interval Between Onset and Death AVS
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w requires s been sign should be	Completed by Ph	Part II. Other significant conditions OLABE ESR	s contributing to death by	ut not resulting in	n the underlying cause given in	Part I.	1 Yes	acco use contribute to s 2 No 3 Pro 24b. Were au	
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To the Hospitel or Attending Physician: within 24 hours after death. yo the Funerel Director: After this certified completely filled in by the funeral director.	Certification:	27. Manner of Death 1	be 390 Blood of Inju	ury - At home, fa	Fime of niury M 28c. Injury at Work? M 1 Yes rm, street, factory, office	2 🗆 No	d. Describe how	v injury occurred eet and Number or Ru	
Hospitel	edical C	29a. Certifier 1 Cartifying (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination an	e, death occurred at the time, dad/or investigation, in my opinior	ate and place, and n, death occurred	due to the cau at the time, dat	use(s) and manner as le and place, and due	stated. to the cause(s)
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3 Sta	te	31. Date filed (Month, Day, Year)	e 5601	Lo Ch ar's Signature	Raven Blva Sporte	1, Balti	more	MDZ	21239
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Andrew J. Jordan	State of Maryland / Departme		ene	21.10
	Registrar	te of Death	Reg. No L U U D	ime of Death
Physician Medical Examine	1. Decedent's Name (First, Middle, Last) The drew J. J.		Month Day Your)428 hrs
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Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24Hrs. 8. Months Days Hours Min.	Date of Birth(MM/DD/YYYY) 9. Birthpla	MULLINGK
Director	130 - 38-6307 1 M 2 F 3 /	Yrs.	07-19-1949 Country) -) - , ,
w any	10a. State 10b. County 10c. City, Town of	Baltimore		I. Inside City Limits Yes 2 No
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21215-003 uld be filed with Mental Hygiene marked other th	Andrew J. Fordan	Mailing Address (Street and Number or Rura	nay Frank	Code)
MD 2 shout th and N n 27 is n numatic	Lula may Jordan - mother.	5334 Cordelia	Are Batto, md.	21215
nore, MD 2	1 Burial 2 Cremation 3 Removal from State cremato	f Disposition (Name of cemetery, pry or other place)	ate 20c. Location - City or Tow	1
altin	4 Donation 5 Other Specify. 21. Signature of Fundral Service Licenses	22. Name and Address of Facility 270	FredHILTON Pa	iss
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of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach	Diabetes mellitus		1 Yes 2 No 3 Probably 24a, Was an 24b, Were autops	y findings available
Cord			autopsy prior to comp performed? death?	letion of cause of
Vital Rec		26.Place of Death (Check only		2 No
Vita ysician his cer direct	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Ou	utpatient 3 DOA Other Nursing H	Iome 5 Residence 6 Other	
ion of Verding Ph	27 Manner of Death 128a Date of Injury 28b	Time of Injury 28c. Injury at Work? 28	d. Describe how injury occurred	
Division of Vital Records, to an Attending Physician: The law requing a flysician: The law requing a flat death. al Director: After this certificate has been sited in by the funeral director, page 2 should the	2 Accident Investigation		f. Location (Street and Number or Rural F or Town, State)	Route Number, City
Divisior To the Hospital or Attentwithin 24 hours after death To the Funeral Director Completely filled in by the	298 Centrel - us t	ath accurred at the time date and place and du		
To the Rewithin 24	(Check only 1 Certifying Physician: To the best of my knowledge, decone) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	nvestigation, in my opinion, death occurred at th	ne time, date and place, and due to the ca	
H- 3 H- 0	29b. Signature and title of certifier	29c, License number O.C.M.E.	29d Date signed (Month, August 1, 2006	Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)			
	24 Date fled (44 of Day) (and 22 Decistrate Supporture	Penn Street, Baltimore, MD 21201		
Sta Registr		Specie		
DHMH 17 Rev 1/200	OR	RIGINAL		

06-05406 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene William Klinefelter 1- For State Certificate of Death Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0922 hrs July 25, 2006 **Medical Examiner** lliam 4c. County of Death 4a Facility Name (if not institution, give street and number) b. City, Town, or Location of Death 8074 Baltimore National Pike Ellicott City Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number Funeral Months Days Hours Director Country) 1 1 M 217-48-3035 Usual Residence of Decedent Oc. City, Town or Location 10d, Inside City Limits s 23a or 28a-f show e notified at once. 1 Yes 2 No Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene ant: If item 27 is marked other than "matural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10e. Street and Number 20143 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14 Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc. White etc Armed Forces? Never Married 2 No Yes 1 Yes 2 No specify Divorced If Yes, Give Year Widowed 4 Specify: à 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle, Maiden Surname) Be KlineFelt lowner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) မ 19a. Informant's Name/Relationship (Type, KlineFelter 20143 lanahan 20b. Place of Disposition (Name of cemetery crematory or other place) Date 2 Cremation 3 Removal from State Important: injury or otl 8-17-06 Donation 5 Crematon Other Specify f Funeral Service Lica PA 18434 AM 1232 Midvalley Dr. Jessup 1), Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and Death allure. List only one cause on each line /Medical Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical XX UNPENDED AMENDED e attending physician for use as the burial item#23a,PII,27,perME,g858,8/7/06 TI Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown has been signed by the 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 V Unknown Chronic alcoholism Completed 24a. Was an 24b. Were autopsy findings available autopsy performed prior to completion of cause of death? certificate has ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Be Other₄ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 2 After 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: n 24 hours arter he Funeral Director: A 1 XX Natural Pending 1 Yes 2 No Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be 3 Suicide or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) July 26, 2006 O.C.M.E. JR, Name and address of person who completed cause of death (Item 23a)

State

Registrar

Theodore M. King, Jr., MD.

AUG 02

2006

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
ament 11 per fh 8558 8-2-06 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 1, 2006 **Physician** KRASNER 4:30 A RACHEL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner LEVINDALE HEBREW HOME BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 08/22/1916 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔽 F Yrs. 89 ISRAEL 215-52-3692 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "netural", or itema 23a or 28a-f show eny injury or other traumatic event, Tra Medical Exacultar must be rediffied at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Director BALTIMORE PIKESVILLE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 407 YESHIVA LANE #1-B 21208 ISRAEL Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME YECHEZKEL SOHN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **TECHEZKELSOHN** SLINKER ELIEZER CHANA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 407 YESHIVA LANE #1-B PIKESVILLE, MD 21208 SHIMON KRASNER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 08/01/2006 BALTIMORE, MD SHEARITH ISRAEL CEM. 4 Donation 5 Other (Specify) 21. Signature Funeral/Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 23a. Part1. Enter the disease, or comblications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.

Immediate Cause (Final 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Immediate Cause (Final HEART FAILURE 4 monts ONGESTIVE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 year Schemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine signed by the attending physician and ibe detached for use as the busine. The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ BENAL PAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Text Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Dey, Year) 125039 080106

1712/209

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LANGOVIN MO.

AUG 0 2 2006

31. Date filed (Month, Day, Year)

2835 Smith Au

ORIGINAL

egistrar's Signature

3

			For State Registrar	tate of Maryland	d / Department of Certificate o			ene2006	24/96
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Jacqueline	Lewis			2. Date of Death Month	30 0 Pear	3. Time of Death 14.38 PM
	Examin Funeral	er	4a. Facility Name (Mot institution, give streem of the Court of Court of Social Security Number 6. Sex	30\ SI Paul 7. Age (In yrs. Is	Place Bal		3. Date of Birth (Month, Day,)	4c. County of Death Baltom 9. Birth Cou	VY-L place (State or Foreign ntry)
	Director		Usual Residence of Decedent 10a. State 10b. County		Yrs. Yrs. , Town or Location		5/10/5	573	Md . 10d. Inside City Limits
	with the Mar s or 28s-f sh be notified	Funeral Director	10e. Street and Number	of est.	1ti.wore	207-		g. Citizen of What Cou	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event. It is Modical Examinal must be multiled at 2008.	ρχ	1 ▼ Never Married 2 Married	Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes ZY No If Yes, Give Year or Dates:	S. 13. Was Decedent of If Yes, specify Co	f Hispanic Origin? (Specuban, Mexican, Puerto R		14. Race - Ameri Black, White, Specify:	
21215-0036	d within 72 ho giene. sr than "natu	Completed	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12) 10th grade		16a. Decedent's Usual Occ (Give kind of work doi life. DO NOT use ret	ne during most of working red)	7	ity of Bali	ŕ
land	2 should be fifed withir and Mental Hygiene. Ie marked other than aumatic event, the Ma	To Be C	17. Father's Name (First, Middle, Last) David	Le	ewis	18. Mother's Name	First, Middle, Ma	aiden Sumame) Holmes	
Maryland	and 2 should leath and Menion 27 le markener traumatic		19a. Informant's Name/Relationship (Type, Stacey Carr	Pnnt) Daughter	19b. Mailing Address (Stree 1110 Somerse				Code) 1202
Baltimore,	Pages 1 and 2 nent of Health ant: If Item 27 ury or other tra		20a. Method of Disposition **Description** **Descriptio	oval from State	lace of Disposition (Name of emetery, crematory or other parties, Pk.	Da (8–5–(oc. Location - City or To andallstow	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	wo arrei	22. Name and Add March F.I	-	Bal LO1 E. N	timore, Md orth Ave.	. 21202
760,	Physician /Medical Examiner	icai Examiner	23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of limited the cause (Final disease or condition resulting in death) Socientially 1st conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	Jopathy. Jencetof): Jence of):	lying, such as cardiac or	respiratory arres		Approximate Interval Between Onset and Death
P.O. Box 687	The law requires that the death certificate site has been signed by the attending physpage 2 should be detached for use as the	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknowh	If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic pregna			23d. Date of deliv Month	ery Day Year
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Il Records,	ding Physician: The law re h. After this certificete has bee funeral director, page 2 sho	Completed by	UI .				24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of 2 No
of Vital	Physician: this certificantal director, j	To Be	1 105 2		EFFOUTPATIENT 3 DOA		e 5 🗆 Resider	ice 6 Other (Speci	fy)
Division of	r Attending P for death. Irector: After t t by the funera	Certification:	National 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At ho building, etc. (Specify	M 1	Vork? □Yes 2□No	Bd. Describe how Bf. Location (Stre City or Town,	eet and Number or Rur	al Route Number,
۵	lospital of hours af uneral Dispital Di	edicai Cer	29a. Certifier 1 Sertifying Physic (Check only 2 Medical Examine)	ian: To the best of my kno	wledge, death occurred at the tion and/or investigation, in m	a time, date and place, a	nd due to the cau	use(s) and manner as s	stated.
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medi	29b. Signature and title of certifier	and manner stated.	29c. Lice	onse number 050484		d. Date signed (Month,	
	5		30. Name and address of person who comp	pleted cause of death (Item			lace B	alt. MD	21702
1000年	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 0 2 2006	32. Registrar's Signa	ture R. Carella				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrat Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4:52 AM 2006 LIXAS SHELTON 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) HOSPIN Johns Hopking If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Sex 1AM 2□F Days Hours Yrs. 212-50-0592 9 - 7 - 48N.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County M☐Yes 2 ☐ No Baltimore NA Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1213 N. Potomac 21213 <u>USA</u> Street 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Specify:Black 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Military 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Reid Lucas Christine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1527 Homestead Street, Baltimore, Md. Ernest Lucas Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition tXBurial 2 ☐ Cremation 3 ☐ Removal from State 8-7-06 Owings Mills, Md. Garrison Forest Vet. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Md. 1101 E. North Ave. wan March F.H. East Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Gastraintes Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of)

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29d. Date signed (Month, Day, Year)

3 Probably 4 Unknown

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Physician

/Medical

Examiner

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Director

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the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Heelih and Manial Hygiene. Important: If Item 27 is marked other then "nature!, or Iteme 28a eny lojury or other treumatic event, the Mandrest enders

Director

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Examiner Physician/Medical þ Be Completed Certification: To

or Attending Physician: The law requires thef the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of

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	case referr	ed to medical		26. Place of Death (Check only one)									
1 🔲 \		40	Hospital: 1 Impatient	2 ER/Outpatient	3	DOA Other:	1 ☐ Nursing H	lome 5 Residence 6 [☐Other (Specify)				
27. Manner of Deat 1 Natural 2 ☐ Accident		5 Pending investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	М	28c. Injury at Work?	2 🗆 No	28d. Describe how injury of	occurred				
	☐ Suicide ☐ Homicide	6 Could not be determined			t, fact	ary, affice		28f. Location (Street and I City or Town, State)	Number or Rural Route Numb	ber,			
29a. Cer	rtifier	Certifying Ph	vsician: To the best of my	knowledge, death o	ccurr	ed at the time.	late and place	e, and due to the cause(s) ar	nd manner as stated.				

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

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29b. Signature and title of certified

31. Date filed (Month, Day, Year) AUG 0 2

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Registrar

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		4	For State Registrer	State of Ma	ryland	d / Departm <i>Certific</i>				Reg. No.	006	24198
	Physicia /Medic	al	1. Decedent's Name <i>(First, Middle, La</i> Gilbert	<u> </u>	0.	La	aws		2. Date of I	Death Day	Year	3. Time of Death 8:53PM
	Examin	er		Hospita Sex 7, Age	(In yrs. Is	enter ast birthday) If U Mon	R nder 1 Year	r Location of De	Irs. B. Date of I	B	9. Birth	MOSE place (State or Foreign ntry)
	Director		Usual Residence of Decedent	1 ∑ M 2□F	89	Yrs.				27–16		Md
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	tor	Md. 10b. County	A		altimore						Yes 2 No
	or 28s	Funeral Director	10e. Street and Number			101	. Zip Code			10g. Citizen		ntry?
	e 23a	erai	1402 N. Decker	Ave.	vor in 11	S 13 Was D	2121		(Specify Yes or		SA Race - Ameri	can Indian
396	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or iteme 23s or 28s-f show any injury or other treumatic event, the Mudical Examiner must be notified at ance.		11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates:			specify Cub		(Specify Yes or i erto Rican, etc.)	E	Black, White cify: Bla	etc.
_ +	in 72 hor n "natura velical I	Completed by	15. Decedent's E (Specify only highest gr	ade completed)		16a. Decedent's (Give kind o life. DO NO	Usual Occup f work done OT use retire	during most of v	working	16b. Kind o	f Business/Ir	ndustry
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Gilb Maryland	uld be file Mental Hy irked oth	To Be (17. Father's Name (First, Middle, Last George	E.	L	aws		18. Mother's Rub	Name (First, Midd Y	fle, Maiden Sun	DeShi	eld
Aary	2 sho rend h		19a. Informant's Name/Relationship	(Type, Print) Daugh	nter	19b. Mailing Add			Rural Route Num	-		o <i>Cod</i> e) 213
	1 end Health		Jacqueline Laws 20a. Method of Disposition	Daugi		lace of Disposition emetery, crematory			Date		on - City or T	
S	Pages lent of nt: If I		1 ☑ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci	Removal from State	- 1	rrison Fo		· -	-3-06	Owing	s Mill	ls, Md.
-awS	permit. Depertrimportal any inju		21. Signature of Funeral Service Uce	unsee Crok	\supset			ss of Facility	1101	Baltim E. Nor		
68760,	hysician //Medical Examiner be preceded by sician street the private transit	edicai Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Ven consequence of the conseq	e. consequence	Throm Jence of): Canc Jence of):	boe	mboli				Approximate Interval Between Onset and Death
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ds, P	uires that signed b	þ	Part II. Other significant conditions	contributing to death bu	ıt not resi	ulting in the underly	ing cause gi	ven in Part I.		d tobacco use d □Yes 2 No		the cause of death?
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Vita	yeician: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	Hospital: V.		FDIO 4 A	J DO A Ot	her	Death (Check on		011 (0-11	
on of	ding Phyeth. th. After this funeral di	tion: To	1 Yes 2 No 27. Manner of Death 1. Natural 5 Pending 2 Accident investigati	28a. Date of Injur (Month, Day	v	ER/Outpatient 3[28b. Time of Injury	28c. Inju	4 NUISIII	g Home 5 ☐ Ro 28d. Describ	e how injury oc		iry)
Divisi	of or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At ho	ome, farm, street, fa	actory, office			(Street and No Town, State)	umber or Ru	ral Route Number,
	To the Hospital or Attendity within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical C	29a. Certifier (Check only one) 1 Certifying F	Physician: To the best of aminer: On the basis of and manner sta	of my kno examina ited.	wledge, death occu tion and/or investig	irred at the t ation, in my	ime, date and pl opinion, death o	ace, and due to t eccurred at the tim	he cause(s) and ne, date and pla	l manner as ce, and due	stated. to the cause(s)
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	m		I me				100	P 63	954	July	28, 2	.006
	(1)		30. Name and address of person who	o completed cause of de 3544 When	eath (Item	23a) (Type, Print)	licate	CIL. M	0 210	43		
	St Regist	ate	31. Date filed (Month, Day, Year) ALIG 0 2 2	32 Registra	ar's Signa	wledge, death occition and/or investig		17,	7 70	•		

			State of Maryland / De	partment of Health and Nertificate of Death	Mental Hygie	3	24199
	Physic /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Edna Francis Lubbert		2. Date of Death	Day Year	3. Time of Death 10:30 AM
	Examir Funeral		4a. Facility Name (If not institution, give street and number) Fairfield Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 218-03-5553	4b. City, Town, or Location of Death Crownsville If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, y OCT 23	Anne Aru	lace (State or Foreign
*	Director Mode p	Jr.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or		001 23		MD Od. Inside City Limits 1 □Yes 2∑No
	72 hours after death with the Maryland neture!', or Items 23a or 28a-f show dical Exeminer must be notified at	by Funeral Director	MD Anne Arundel Crowns 10e. Street and Number 323 S. Riverside Drive	10f. Zip Code 21032		Citizen of What Cour	ntry?
9003	nours after de urel', or Itema I Exeminer n	d by Fune	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Stiff Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 √ No Specify: 		14. Race - Americ Black, White, Specify: Whit	etc. Ce
121215-0036	iled within 72 h lygiene. her then "netu nt, tre Medica	Completed	(Specify only highest grade completed) (Gillife Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation we kind of work done during most of work . DO NOT use retired) emaker	king	Wn Home	fustry
Maryland	2 should be fi and Mental H le marked ot aumatic ever	To Be	Charles Talley		Talley I	ogis	Code)
Baltimore, M	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "neturel", or Items 23s or 28s-f show any injury or other traumatic event, tra Medical Examiner must be nutified at once.		20a. Method of Disposition 1 Burial 2 Communication 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Discemetery, or cemetery, or Metro Cr	rematory or other place) cematory, Inc 8/2/(Date 20	c. Location - City or To Baltimore	wn, State
Balt	Depart Depart Import any in		21. Signature of Funeral Service Licenses G. Todd Dring 23a. Part 1. Enter the disease, or complications that caused the death. Do not established, or heart failure. List only one cause on each line.	22. Name and Address of Facility Cremation Society of 299 Frederick Rd Ba enter the mode of dying, such as cardiac	Itimore	MD 21228	Approximate Interval Between
68760,	Physician be executed the sicial of the state of the stat	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	Fibrillation presmonia			Onset and Death
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Vital Re		Be	25. Was case referred to medical examiner? 1 Yes 22 No	0.1	autopsy performe 1 Yes 2	prior to cor	npletion of cause of 2□ No
Division of Vital Records,	Jing After fune	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 2 Sea. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Place of Injury - At home, farm, building, etc. (Specity)	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	injury occurred et and Number or Rura	
Ö	To the Hospitel or Attentwithin 24 hours after death To the Funerel Director:	edical Ceri	29a. Certifier (Chack only one) Certifying Physicien: To the best of my knowledge, de (Chack only one) Certifying Physicien: To the best of my knowledge, de (Chack only one) and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the caus	se(s) and manner as st	ated. the cause(s)
	within 2. To the P	W	29b. Signature and title of certifier All and all and address of person who completed cause of death (Item 23a) (Type)	29c, License number MD 59/9	7.f 8	Date signed (Month, 1	Day, Year)
	Sta Regist	ate rar	31. Date filed (Month, Day, Year). 32. Registrar's Signature	70 1201	- JOPPA	a RD, To	owson, M
DH	IMH 17 Rev 1/2	2001	AUG 0 2 2006 Black D A	INAL			

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 **Physician** Margaret McCollum Day Year 31 2006 6:45a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington Hospital Prince's George Ft. Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6–10–28 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛣 F Director 255-34-6381 78 Yrs Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23e or 28a-f ehovedical Examiner must be notified at Director Y☐Yes 2☐No Md. Prince's George Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 USA 217 Eagle Head Dr. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Battimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Ď Specify: Black 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry f other then " Elementary/Secondary (0-12) College (1-4or 5+) Teaching Parent State of N.J. 12th grade 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) is marked Hiram Morgan Jessie Dozier ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Item 27 i 217 Eagle Head Dr., Ft. Washington, Md. 20744 Alberta McCollum Daughter 20b. Place of Disposition (Name of cometery, crematory or other place, Shady Grove Cem. 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any injury or oti once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-12-06 Hoke, N.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 & a March F.H. East 1101 E. North Ave. Won 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** reast 1-Pars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sicien end b The law requires that the death certificate be executed Due to (or as a consequence of): .O. Box 68760 physicien by Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 DEctopic pregnancy Month Day 4☐Pregnant at time of death signed by the at d be detached for 5 Other (specify) 9 Unknown 9 ☐ Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No Completed 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 2 2 No 1 Yes 2 No Division of Vital 1 Yes To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? director 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 28c. Injury at Work? 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32800 30. Name an address of person who com e excause of death (Item 23a) (Type, Print) #205 Ft Washington MD 20744 Herbert Washington 11701 Livingston Rd 32 Registrar's Signature 31. Date filed (Month, Day, Year) AUG 0 2 2006 State Registrar

		•	1 - For Amend #2	State of M 29d Per Ph	laryland / y G858	Depa 8 <i>Cer</i>	irtment of H 06 JH tificate of L	ealth and I Death	Mental Hygi	ene ()6	24201		
			1. Decedent's Name (First, Middle, La	ist)					2. Date of Death Month	Day	Year	3. Time of Death		
н	Physicia /Medic		Frances Loretta	a Menzel					July	28 , 200	_	9:28 A M		
Н	Examin		4a. Facility Name (If not institution, gir	e street and number)		4b. City, Town, or	Location of Death	1	4c. County	of Death			
			Charlestown Car					nsville			imor	e e		
	Funeral Director		214-18-6326	Sex 7. A 1 □ M 2 X F	ge (In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct 16,	1920	Cour	lace (State or Foreign htry) Land		
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation		·		1	0d. Inside City Limits		
	Maryi f sho	ĕ	Maryland Balti	moro	Ca	tons	ville					1 ☐ Yes 2 XNo		
	the	Director	10e. Street and Number	HOLE			10f. Zip Code		10	g. Citizen of W	hat Cour	itry?		
	h with		709 Maiden Choice	Lane			2122	.8		USA				
	deat	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S.	13. \	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S	pecify Yes or No- o Rican, etc.)		- Americ	an Indian,		
36	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28e-f show the Modical Examirer must be notified at		1 Never Married 2 Married	1 □ Yes 2 🔀 If Yes, Give	No	1	☐ Yes 2X No	Specify:	o thousand ottoly		Whi			
Ö	hours tural',	10a. State 10b. County 10c. City, Town or Location							16b. Kind of Business/Indu					
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<u>lai</u>	2 should be i and Mental I Is marked o reumatic eve	2	Bernardo Carir	gi				Laure	etta Unk.					
lan	2 shc and Is ma		19a. Informant's Name/Relationship	•			•		ral Route Number,	•	•			
6	1 and 1ealth 9m 27 ther to		Loretta Knox,	Daughter			Davis Av	enue Woo	dstock, N	Marylan Oc. Location - (
Jor	in of h		1 XBurial 2 ☐ Cremation 3 [cemet	ery, cren	natory or other place	1			•	555		
Baltimore, Maryland 21215-0036	iit. Pa intmer injury ii.	9	* 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Loudor		rk Cemete	_)1/06 I	Baltimo	re,	Maryland		
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other treumatic evonce.		Thomas Gregor	5			MacNabb F	uneral H	lome P.A. Id Catonsy	zille.	Marv	Land 21228		
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each	d the death. Do	not ente	er the mode of dying	, such as cardiac	or respiratory arres	st,		Approximate Interval Between		
н	Physician		Immediate Cause (Final disease or condition Onset and											
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence	∍ of):								
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9	artifica ing ph e as t	Med	IF FEMALE:							1				
Вох	eath certific attending p for use as	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal deat		Ectopic pregnancy			23d. Date Mon		ry Day Year		
o.	the d	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant : 9☐ Unknown	at time of death	5∟	Other (specify)					,		
<u>α</u>	that the	y Ph	Part II. Other significant conditions	contributing to death	but not resulting	in the ur	derlying cause give	n in Part I.	23e. Did toba	icco use contri	bute to th	e cause of death?		
Records,	quires tha n signed uld be del	d by							1 ☐ Yes	2 🗆 No	3 🗌 Prob	ably A Unknown		
S		Completed							24a. Was an	24b. W	ere autor	osy findings available		
æ	0 2 0	E O							autopsy performe 1 ☐ Yes 21	gd? de	eath?	npletion of cause of 2 No		
Vital		Be C	25. Was case referred to medical					26. Place of Dea	th (Check only one,					
of V	9	To	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpat		utpatien	: 3□ DOA Othe	r: Nursing H	ome 5 Residen	ce 6 □Othe	r (Specify)		
0			27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D	ury 28b. a <i>y Year)</i>	Time of Injury	28c. Injury Work		28d. Describe how	injury occurre	d			
sio	Attending r death. sctor: Afte by the fune	cati	2 Accident investigation 3 Suicide 6 Could not to			es 2 □No	DOG 1 (Ct	-4		(Book Market				
Division	el or Attend s after death al Director: , ad in by the f	27. Manner of Death 27. Manner of Death 28. Date of Injury 28b. Time of Injury 28b. Time of Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Date of Injury 4 Work? 28c. Date of Injury 4 Work? 4 Homicide 28c. Date of Injury 4 Work? 28c. Date of Injury 4 Yes 2 No 28c. Date of Injury 4 Yes 2 No 28c. Date of Injury 4 Yes 2 No 28c. Date of Injury 4 Yes 2 No 28c. Date of Injury 4 Yes 2 No 28c. Date of Injury 4 Yes 2 No 28c. Date of Injury 4 Yes 2 No 28c. Date of Injury 4 Yes 2 No 28c. Date of Injury 4 Yes 2 No 28c. Date of Injury 4 Yes 2 No 28c. Date of Injury 4 Yes 2 No 28c. Date of Injury 4 Yes 2 No 28c. Date of Injury 4 Yes 2 No 28c. Date of Injury 4 Yes 2 No 28c. Date of Injury 5 Yes 2 No 28c. Date of Injury 6 Yes 2 No 28c. Date of Injury 7 Yes 2 No 28c. Date of Injury 8 Yes 2 No 28c. Date of Injury 9 Yes 2 No 28c. Date									r or Hurai	Houte Number,		
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical (hysician: To the bes miner: On the basis and manner s	of examination a									
	Tot Total	Ž	29b. Signature and title of certifier	wh			29c. License	7447	29 A	uly 28	200¢	Day, Year)		
	10		30. Name and address of person who	completed cause of	death (Item 23a	(Type,	Chox	Lano	Caten	sui6	Mar	1		
	Sta Registr	_	31. Date filed (Month, Day, Year) ALIG 0 2 2	-	trar's Signature	A	out !				-			
			HUG U & C	A PROPERTY		1								

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate Registrar Certificate		Reg No.					
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle, Last) Joseph William Mo		2. Date of De Month July 25,	Dav	Year	3. Time of Death 1736 hrs		
		Facility Name (if not institution, give street and number) Anne Arundel Medical Center	4	4b. City, Town, or Lo Annapolis	cation of	Death		ounty of Deat e Arunde	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthda)	/)	If Under 1 Year	If Under	24Hrs 8. Date of I	Birth(MM/DD/		rthplace (State or
Director		217 86 9874 1XM 2F 41	Yrs.	Months Days	Hours	Min. Sept.	4, 19	964 Forei	ountry)Maryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocatio	on					10d. Inside City Limits
ž .	_	Penna. York Shrewsb	ıry	I					1 Yes 2X No
with the Maryland us 23a or 28a-f show be notified at once.	Director	10e. Street and Number		10f. Zip Code			10g. Citizen	of What Cou	untry?
n the A		315 S. Main Street		17361 U.S.					
ath wit	Funeral	1 Never Married 2 Married Armed Forces?						Race - Ame White, etc.	rican Indian, 8lack,
fler death		1 Yes 2 No 3 Widowed 4 Divorced If Yes (Sive Year or Dates:		Yes 2X No	specify:		Spe	ecify Whi	ite
The street and Number 10e. Street and Number 10e. Street and Number 10f. Zip Code 11g. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Give Year or Dates: 11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 15 Decedent's Education (Specify only highest grade completed) 16 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)								of 8usiness	/Industry
3 Widowed 4 Divorced If Yes, Give Year 1 Yes 24 No specify: Specif								- 9 Do	ogs
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Self Employed K - 12th 12th Self Employed K - 27 and the first of									46-95-5
nore, MD 2121 ages 1 and 2 should be fi nr of Health and Mental tt: If item 27 is marked other traumatic event,	٩	19a Informant's Name/Relationship (Type, Print) 19b M Deborah Morris / wife 315	ailing S	g Address (Street a • Main St	and Numl reet	ber or Rural Route N Shrew	umber, City o S bury ,	r Town, Stat Penna	e, Zip Code) a. 17361
- v = = =	ŀ	l == '		ition (Name of ceme	tery,	Date	20c. Loca	ation - City o	r Town, State
more, header of Health	-	A Burial 2 Cremation 3 Removation State		n Mem. Pa	rk	7/31/2006	G1en	Burni	ie, Maryland
Baltimore, permit Pages I an Department of Hea Important: If iter	Ì	21. Sig of uneral Service Lens()	22. N	lame and Address o	f Facility	Gonce Fun	eral S	ervice	e, P.A.
		23a Part I Enter the disease, or complications that caused the lieath. Do not er							and 21225 Approximate Interval
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18760, ritificate be ing physici as the buri	Me	IF FEMALE: 23c. If yes, outcome of pregnancy				pregnancy		ate of delive	ry Day Year
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Div oital or ours aft eral Di	Certification:	Suicide 6 A Could not be determined (Specify) found in 1	esi	idence		Crowns	ille, M	2 Genera	als Highway
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a Certifler 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner:On the basis of examination and/or inve							
To 4	Medical	and manner stated 29b. Signature and title of certifier		29c. License					onth, Day, Year)
01 6		Mly Brassell MA		O.C.M	.E.		ı	7, 2006	
	1	30. Name and address of person who completed cause of death (Item 23a)	_	c - nilities					
101	li N		11 P	Penn Street, Ba	Itimore	e, MD 21201			
St Regist	ate trar		00	de					
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Lapreia Mcrae State of Maryland / Department of Health and Mental Hygiene 1- For State Reg No. Certificate of Death Reg No.									2420							
Physicia		Registrar 1. Decedent's Nam	e (First, Midd	le,Last)						_	2.	Date of D	eath	· — —		Time of Death
Medical Exami	ner	LaPrei				oria		M	IcRa	e		Month July 27,	2006	Year		2007 hrs
		4a. Facility Name (i Sinai Hospit		n, give	street and nu	mber)		b. City, To		ocation of	Death		40	c. County of I	Death	
Funeral		5. Social Security N		6 Sex		7. Age (In yrs	s. last birthday)	If Under		If Under	24Hrs.	8. Date of	Birth (MM	/DD/YYYY)	9. Birthpl	ace (State or
Director				1 1	и 2 <mark>X</mark> F		1 Yrs	Months	Days	Hours	Min.	12	26	94	oreign Countr	y) MD
		215-43- Usual Residence of			22							12		J-1		1110
amy	ſ	10a State	10b. County		_	10c. Ci	ity, Town or Locat	on								d Inside City Limits
Maryland 28a-f show any <u>d at once.</u>	اةِ ا	MD	N	A			Baltimo									Yes 2 No
Mary r 28a- ed at	Director	10e. Street and Nu	mber					10f. Zip C	ode				10g. Citizen of What Country?			?
th the		3812 Co	ttage	Αy	e	.ae	110 140 14	21215 Decedent of Hispanic Origin? (Specify Yes or No-					U.S.A. 14. Race - American Indian, Black,		Indian Black	
ath wi	Funeral	11. Marital Status 1 X Never Marrie	ed 2 M	arried	Armed Fo		If Y	s Decedent es, specify					NO-	White,		Indian, Black,
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MD id 2 sho lith and in 27 is aumati		Calvin		-Fa	ther											Md 21207
re, s l and f Heal ff item er tra		20a. Method of Dis 1 X Burial 2		n 3	Removal fr		 b. Place of Dispos crematory or otl 		of ceme	etery,		Date	20c.	Location - C	ty or Tov	vn, State
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ranter of Health and Mental Hygiene frant: If iten 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5	Other S	pecify:			ing Men	oria	1 P	ark	8/3	/06	R	andal	lst	own, Md
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is warked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of Fu	ineral Service	Ligense) / L	-	22 M	ame and A	ddress (of Facility Wes	st					
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876 ificate ig phy s the t		IF FEMALE: 23b. Was decedent		he	23c. If yes,	outcome of pr		tal death	3	Ectopic	pregnanc	v	23	3d. Date of de Month	livery Day	Year
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cords, P.O. law requires that the has been signed by 2 should be detach.	ted	 									_	24a Wa				sy findings available
SOFC law re has be 2 sho	Completed	_			_							au	opsy formed?	pric	r to com	pletion of cause of
tal Rec ician: The la certificate h	Š		 						Diana	of Donath /	Phasis and	1 Ye	s 2 N	No 1 🗸	Yes	2 No
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VISION Att Or Att Cher de Directo	iţica	2 Accident 3 Suicide		stigation ald not be	28e Plac		t home, farm, stre	et, factory, o	office bu	ilding, etc.	. 28	Bf. Location or Town		and N umber	or Rural	Route Number, City
Divisior ospital or Attend hours after death nueral Director:	Certification:	4 Homicide	dete	ermined	(Specify)	residenc	ce				38	312 Cott	age Av	enue, Bal	timore	MD
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical (29a. Certifier (Check only one) 2					ledge, death occu n and/or investiga									use(s)
To 1 To 1	Med	29b Signature and	1		and manner s	stated		29c	License	number			29d.	Date signed	(Month,	Day, Year)
	_	DT 1	1000	-	- 12	001			O.C.N	1.E.			Jul	y 28, 2006	3	
		30. Name and add	ress of perso	n who co	ompleted cau	se of death (II	tem 23a)				-					
2		Patricia Arc					al Examiner	111 Pe	nn Stre	eet, Bal	timore,	MD 212	201			
S	tate trar	31. Date filed (Mor.	"AUG"	2 20	06 32. R	distrar's Sign	nature	artes								
1.09/2	2004				-				-							

Please Type or Print in Black Indelible Ink

06-05486

2420

1 - For State Registrer Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 22, HAZEL MILLER July 2006 8:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | (Month, Day, Year) | Ohio | Ohio 7. Age (In yrs. last birthday) **Funeral** 219-01-9448 Months 1 □ M 2 🛛 F Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural; or Items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at MXYes 2 No Annapolis Maryland Anne Arundel Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21409 USA 84 Old Mill Bottom Road North by Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2X No Yes, Give 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 4 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clara Wakefield 2 Albert C. Hofrichter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is sny injury or other trai once. Margaret A. M. Wolff (Daughter) 1707 Marshall Court - Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State Rehoboth Presbyterian 7/31/2006 Rehoboth, Maryland 4 Donation 5 Other (Specify) Gemetery Brandshaw & Sons Funeral Home 21. Signature of Funeral Service Licensee

Mary Beth Bradshaw—Pruitt 306 W. Main Street - Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disease **Physician** COYUNAVY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner en evalize 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed hed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Vementia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 211 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attending 1 Matural 5 🗌 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 17965 July 22, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 116 Detense 32. Registrar's Signature State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene? 🛛 🗍 💍 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** TCIA 730 50 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Uniter Stay of Many land the dreal lenter If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye July 20, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year) Months Min 1 M 2 F Hours 213-36-0726 65 Yrs. 1941 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3501 Frankford Avenue or iteme 23a 21214 <u>USA</u> by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Chester Sinsko Freda Stevenson ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Macfarlane, Daughter 1318 Berwick Road Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 07/31/06 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland 22. Name and Address of Facility
Cremation Society Of Maryland Inc.
299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service picensee
Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pancreat Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Clus to (or as a nonsequence of) Examine burial-transit and The law requires that the death certificate be execu Due to (or as a consequence of): Box 68760. attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Year 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the the detached 9 Unknown 9 Onknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ , page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an hes 1 ☐ Yes 2010 Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 npatient 2 ER/Outpatient 3 DOA this by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? After 1 Natural Injury 5 Pending death. 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 5 30. Name and address of perso / o complet use of death (Item 23a) (Type, Print) Kar 32. Redistrac's Signature 31. Date filed (Month, Day, Year) State AUG 0 2 2008 Registrar

Doctors Hospital Funeral Director 5. Social Security Number 254-82-9357 1 M 2 F 60 Yrs. Mont		July 12,	Day Year 2006 4c. County of Death		
4a. Facility Name (If not institution, give street and number) Doctors Hospital Funeral Director 5. Social Security Number 254-82-9357 Livel Registers of December. 4b. C	Lanham, Md. Ider 1 Year If Under 24 Hrs. Its Days Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Death		
Director Section of December 1 March 1	ths Days Hours Min.	(Month, Day, Ye		P.G.	
Usual Residence of Decedent		Oct. 9, 1	ear) Cou	place (State or Foreign intry) na11, GA	
10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 X Yes 2 No	
MD P.G. Bowie 106. Street and Number 15756 Pointer Ridge Drive 11. Marital Status 1 Never Married 2 Married 1. Yes 2 Mo	. Zip Code 20715	10g.	Citizen of What Cou		
The part of the pa	ecedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto ss 2∰ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Bla	, etc.	
Second of the second of the	Usual Occupation If work done during most of work Of use retired) UCC FOOD Clerk	ing	Giant F	-	
Duby Day Line of the control of the		e (First, Middle, Mai	Giant Food He, Maiden Sumame)		
19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Additional Section 15756 Pc	ress (Street and Number or Rur Dinter Ridge Dr	ive, Bowi			
20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition 20c. Place of Dispo	or other place) netery 7/	27/06 R	c. Location - City or 1	, GA	
21. Signature of Funeral Service Licensee 22. Name 389 F	e and Address of Facility Fra Rhode Island Av	enue, N.W	., Washin	gton, DC200	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ESOPHAGEAL CARCINON ESOPHAGEAL CARCINON	O SEPSIS THY LEEP	or respiratory arrest,		Approximate Interval Between Onset and Death	
IF FEMALE: 23c. If yes, outcome of pregnancy	ic pregnancy		23d. Date of delin	very Day Year	
र्फ कु कु कु कु कु कु कु कु कु कु कु कु कु	ing cause given in Part I.		cco use contribute to 2 ☐ No 3 ☐ Pro		
Name of the property of the pr		24a. Was an autopsy performed	d? prior to c	opsy findings available ompletion of cause of 2 No	
	Othor	th <i>(Check only one)</i> ome 5 ☐ Residenc	e 6 □Other (Spec	ify)	
De State St	28c. Injury at Work? 1 □ Yes 2 □ No ctory, office	28f. Location (Stree	et and Number or Ru	ral Route Number,	
29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 20 Medicel Exeminer: On the basis of examination and/or investigation.					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	29c. License number D61552 k Road, Lanham	Ju	Date signed (Month		
State Registrar AUG 0 2 2006 KEVIN K. EREAN, M.D. 8118 Good Luck 31. Date filed (Month, Day, Year) AUG 0 2 2006					

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene Franklin Vincent McKnight

Tank.	n vinocin		1. For State Certificate of Registrar Certificate of		Re	g. No. 000	0 0100
	Physicia	n/	Decedent's Name (First, Middle,Last)		2. Date of Death Month	Day Year	3. Time of Death — U 0942 hrs
Medic	al Exami		FRANKLIN VINCENT MCKNIGHT 4a. Facility Name (if not institution, give street and number) 4	b. City, Town, or Location of D	July 30, 20	4c. County of Death	00 12 1110
			3604 Monterey Road Apt. E	Baltimore		N/a	
	Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 217 70 0654 1 M 2 F 49 Yrs.	If Under 1 Year If Under 24 Months Days Hours	Min. SEPT.	h(MM/DD/YYYY) 9. Birth 28,195 Foreign Cou	Ny, C.
	4 e	-	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location	on		T	10d Inside City Limits
	nd how a		ND. N/A BALTIMO	RE			1 X Yes 2 No
	the Maryland a or 28a-f show any tifted at once.	Director	10e. Street and Number 3604 MONTEREY ROAD	10f. Zip Code 21218	10	og. Citizen of What Count USA	try?
	hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.	Fune	1 Never Married 2 Married Armed Forces? If Ye 1 Yes 2 V No	Be Decedent of Hispanic Origin? Best specify Cuban, Mexican, Pu Yes 2 X No specify:		Specify: BLAC	
	72 hours af "natural al Examin	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a Decedent	's Usual Occupation (Give kind ost of working life. DO NOT use	d of work done e retired)		CHILLINGS
9036	vithin ene er than	<u>d</u>		DRIVER		TRUCKING	co.
MD 21215-0036	pormit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	Be	17. Father's Name (First, Middle, Last) JAMES HOWARD		NA WALKE	ER	Zin Cada)
0.2	shoulk and M 7 is m	유		E. 33RD ST.			Zip Code)
	Health item 2	-	20a. Method of Disposition 20b. Place of Disposi	tion (Name of cemetery,	Date	20c. Location - City or 1	Town, State
20	Pages ent of at: If		1 Burial 2 Cremation 3 Removal from State MT . Z I ON	CEM. A	UG.08,20	06 BALTO,	MD.
Baltimore	epartm nporta		21 Anature of Funeral Service Licensee 22. N	ame and Address of Facility LVIN B. SCRU	GGS FUNE	ERAL HOME	
	hysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	2 F PRESTO	N ST BZ	ALTO, MD 2 est, shock, or heart	1213 Approximate Interval
	Medical	g h	failure. List only one cause on each line. Immediate Cause (Final disease a Intracerebral hemorrha e				Between Onset and Death
	xaminer		or condition resulting in death) Due to (or as a consequence of):				
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
1	ed sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
V	cate be executed physician and the hurial - transit	ical	X UNPENDED AMENDED it con#230 DIT 27 p	ME 050 0/10/00	ATTI		
9	cate be		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
20 687		Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fe Fe Pregnant at time of death 5 Ott 9 Unknown	tal death 3 Ectopic pr ner (Specify)	regnancy	Month D	ay Year
	at the d I by the tached			inderlying cause given in Part I	1	bbacco use contribute to t	
۵	ircs the signed	d by			_ ,	S 2 No 3 Prob	and exception occurrence
70	Law require has been so 2 should be	Completed			24a. Was autop		topsy findings available ompletion of cause of
0	tal ReCC ician: The la certificate ha rector, page 2	Com			1 ✓ Yes		s 2 No
19	VICAL F ysician: his certifi director,	Be	25. Was case referred to medical examiner?	26 Place of Death (Cl		Residence 6 🗸 Other	: Scene
7,90	fing Physic After this funeral dire	1: To	27 Manner of Death 28a Date of Injury 28b Time of	njury 28c. Injury at Work?		how injury occurred	
	ION Itendin Beath tor: A	atio	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 N			
	DIVISION OF VIGAL RECORDS, F.O. DOX 90, To the Hospital or Attending Physician: The law requires that the death certificate 19 their Enteral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:			or Town, S		
	LJIVIS To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical (Certifying Physician: To the best of my knowledge, death occur (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	tion, in my opinion, death occur	e, and due to the caus rred at the time, date	and place, and due to the	e cause(s)
	FSFO	ž	29b. Signature and title of certifier	29c, License number O.C.M.E.		29d. Date signed (Mor	nth, Day, Year)
	ord		20. Name and and floor of program who correlated on one of death (floor 22c)	O.O.IVI.E.		301, 51, 2000	
	1 pura		30. Name and ad Yess of person who complified cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Per	nn Street, Baltimore, MI	D 21201		
		tate	8110 0 0 2800 1 6 6 7				
DU	Regis MH 17 Rev 1/						
DHI	**** 17 1764 /	2001	ORIGINA	i ten			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? [] [] [1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Miller Month Day Year 1305 M ratricia 07 28 2006 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 □ M 2 💢 F Hours 215-30-3456 Jan. 6, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No <u>Maryl</u>and Baltimore Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 6100 Shipview Way 21224 u. s. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10th Grade Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Hirsh Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Keith Miller (Son) 18 3rd Ave. South, Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem. Park 08/02/2006 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Due to (or as a consequence of): rachae bronchi tis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of). ventilater dependence Chronic that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dighetes Mellitus Hypertension, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy 1 Yes 2 No 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Mnpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury

Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and ò signed by the a d be detached f

Physician

/Medical

Examiner

Funeral

Director

28a-f ehow

6

Director

Funeral

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Completed

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treumatic event, the Madical Examiner must be notified at

other

permit. Page Department of important: If any injury or once.

the Maryland

deeth v or iteme 23a

Pages 1 end 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other than "naturei", or ite

Baltimore, Maryland 21215-0036

Examine Physician/Medical Completed by icete hes been sign. page 2 should b Be ŧ ဥ 24 hours after death.
• Funerel Director: After the etely filled in by the funeral

Division of Vital Records. P.O. Box 68760.

Medical Certification:

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 ☐ Accident 3 Suicide 4 ☐ Homicide

29a. Certifier

Alan

5 Pending investigation

6 Could not be determined

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

D320

1 ☐ Yes 2 ☐ No

MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

31. Date filed (Month, Day, Year) AUG 0 2006

Schwartz

4940 Eastern Avenue Baltimore 32. Registrar's Signature

DHMH 17 Rev 1/2001

within 24 ho To the Func completely fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tens 1,8 per 1h 2858 8-2-06 vt. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. ... 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY 30, 2006 Year **Physician** MARDER ROBERT 6:16 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner REISTERSTOWN BALTIMORE 8 VICTORIA GREEN COURT Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1943
Months Days Hours Min. (Month, Day) 1941 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 62 -MD 219-42-1146 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or Items 23s or 28s-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No MD BALTIMORE REISTERSTOWN Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8 VICTORIA GREEN COURT 21136 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Marned WHITE Saltimore, Maryland 21215-0036 1 Yes 2 No þ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Menial Hygiene. Important: If Item 27 is marked other than "ns any injury or other treumatic event, the Media 2008. HEALTH Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER SUPPORT NAT'L INSTITUTE OF 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARDER URIEFF CARL FANNIE JAMES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8 VICTORIA GREEN COURT - REISTERSTOWN, MD 21136 JOAN MARDER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buriaf 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM | 08/01/2006 4 □ Donation 5 □ Other (Specify) REISTERSTOWN, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. wa 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Finat disease or condition resulting in death) Physician 40card. 11 /Medical Due to (or as a consequence of): Examiner Coronory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Thysicien and Due to (or as a consequence of) pertonsing Division of Vital Records, P.O. Box 68760 Physician/Medical the for use as ate has been signed by the attending I page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Hyperlipidaniy Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 No certificate has 2 No 1□ Yes 1 Yes To the Hospitel or Attending Physicien: tuneral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA After this 27. Manuer of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 3

Registrar DHMH 17 Rev 1/2001

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1945500, m.p

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month Da July 29, 2006 0254 hrs **Medical Examine** 4c. County of Death 4a. Facility Name (it/not institution, give street and number) 4b. City, Town, or Location of Death University Hospital Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (tn vrs. last birthday) **Funeral** Foreign Min Months Hours Directo Country) MARYLANI 1 X M 2 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits any 1 X Yes 2 No 28a-f show notified at once hours after death with the Maryland Director 10e Street and Number items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Funeral 11. Marital Status 12 Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' Never Married 2 Married 2 X No Yes 4 Divorced If Yes, Give Year Yes 2 No specify: Specify: ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical Enjury or other traumatic event, the Medical 21215-0036 17. Father's Name (First, Middle, Last) Be ANDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru- | Route Number, City or Town, State, Zip Code) HN7 HON1 TIMORE. 20c. Location - City of Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Donation 5 Other Specify 21 Societure of Funeral Service Licenses .21217 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, shock, or hear Physician Retween Onset and failure. List only one cause on each line /Medical Death a. Gunshot Wound Of Neck Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED AMENDED attending physician or use as the burial O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown s been signed by the should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, P. Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of After this certificate has funeral director, page 2 sl performed' death? 1 🗸 Yes ✓ Yes 2 No 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other₄ ER/Outpatient 3 V DOA Nursing Home 5 Residence 6 Other 2 Inpatient မ 1 V Yes 28a. Date of Injury (Month, Day Year) Jul 29, 2006 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work 27. Manner of Death To the Hospital or Attending I within 24 hours after death To the Funeral Director: Afte Certification: Subject shot 0226 hrs Natural 1 Yes 2 ✔ No 5 Pending in by the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) 700 Cooks Lane, Baltimore, determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 29, 2006 and 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 David Fowler M.D. Chief Medical Examiner 31. Date filed (Month, Day, Year) State Registrar

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State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar Certificate of	Death R	2006 2421
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	Date of Dea Month	th 3. Time of Death
Medical Examiner	FasTo OFTZ 4a. Facility Name (if not institution, give street and number)	July 29, 2 4b. City, Town, or Location of Death	4c. County of Death
	University of Maryland	Baltimore	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	th (MM/DD/YYYY) 9. Birthplace (State or Foreign
	None 1 M 2 F 27 Yrs. Usual Residence of Decedent	09/	06/78 Country) Mexico
* any	10a. State 10b. County 10c. City, Town or Locati	on	10d. Inside City Limits
yland f shov once,	NA VA Caderext		1 Yes 2 No
nore, MD 21215-0036 gass 1 and 2 should be filed wittin 72 hours after death with the Maryland nt of Health and Mental Hygiene it. If item 27 is marked other than "natural", or items 23a or 28a-f show any other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Cerro Prieto	N.A.	0g. Citizen of What Country? MEXICO
triems 23a nust he noti uneral [11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	s Decedent of Hispanic Origin? (Specify Yes or No	- 14. Race - American Indian, 8lack,
or iter	1 Yes 2 No	es, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
atural", aminer	Lor Dates:	Yes 2 No specify: Mexical t's Usual Occupation (Give kind of work done	Specify: HIS Panic
6 72 ho m "na cal Ex	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use retired)	- 10
5-0036 ed within 72 ho tygiene other than "na the Medical Ex	17. Father's Name (First, Middle, Last)	Laborer 18. Mother's Name (First, Middle, I	Farm Worker
21215-0036 Juld be filed within 7 Mental Hygiene marked other than cevent, the Medica			
D 21 hould I nd Mer is man affic ev	Alberts Cospai Ortiz Ravnen 19a Informant's Name/Relation ip (Type Print) (Brother) 19b Mailing Jese Tuen Ortiz 219	Address (Street and Tumber or Rural Route Num	nber, City or Town, State, Zip Code)
Baltimore, MD 21215-00; permit Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Mediumy f the Medium of t	20a. Method of Disposition 20b. Place of Dispos	ition (Name of cemetery, Date	14 10 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
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Baltimo permit Page Department Important: injury or ot	4 Donation 5 Other Specify: Price Call 21. Structure of Funeral Service Licensee 22. N	ame and Address of Facility Russ F/1	4 P.A
	23a. Part I Enter the disease, or complications that caused the death. Do not enter the	222 D. North 400	
Ph sician / edical	failure. List only one cause on each line. Complications of	f Necrotizing Fascitis	est, shock, or heart Due to Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		
er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
ed nsit	cause. Enter Underlying Cause (Disease or injury that initiated		
	events resulting in death) Last Due to (or as a consequence of): d.		
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3760, ificate be exprision as the burial	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fel	tal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
b, Box 687, the death certifity the death certifity by the attending ched for use as the Physicians	past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fell 4 Pregnant at time of death 5 Ott	ner (Specify)	
ш э ды д	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I. 23e. Did to	obacco use contribute to the cause of death?
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Records, The law require. Freate has been sig.; page 2 should bb. Completed		perfo 1 ✓ Yes	rmed? death? 2 No 1 Yes 2 No
Vital Rec hysician: The this certificate I director, page To Be Con	25. Was case referred to medical examiner? Hospital: Impatient 2 ER/Outpatient	26.Place of Death (Check only one) 3 DOA Other Nursing Home 5	Davidson o Ou
n of V ing Phys After this funeral di	27. Manner of Death 28a. Date of Injury 28b. Time of In	Tursing floring	Residence 6 Other:
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Division or spirat or Attending tours after death neral Director: After filled in by the function:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stree	et, factory, office building, etc. 28f. Location (or Town, S	Street and Number or Rural Route Number, City state)
	29a. Certifier 1 Continue Division To the best of multipopulation doubt acquire	red at the time, date and place, and due to the cause	se(s) and manner as started
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate I completely filled in by the funeral director, page Medical Certification: To Be Corr	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated.		
- F & F & B	29b. Signature and title of certifier	29c License number	29d Date signed (Month, Day, Year)
Dord .	wayne meyoul	O.C.M.E.	July 30, 2006
101	Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Personal Control of the Cont	enn Street, Baltimore, MD 21201	
State		roles	
Registrar	URIGINAL		
2 1/2001	ORIGINAL	<u>_</u>	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^Df^y, 2006 August **Physician** Pfeil 8:30a M J. Henry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist 8. Date of Birth 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Pennsylvania 1X M 2 □ F Yrs. 60 207-38-8107 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r then "netural", or items 23s or 28s-f show the Medical Exerciper must be notified at Germantown 1 ☐ Yes 2 No Montgomery MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 USA Esmond Terrace 19251 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ½ Yes 2 □ No 1967 -If Yes, Give Year or Dates: 1969 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status Black, White, etc. filed within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ρ White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mentel Hygiene.
Important: If item 27 is marked other then "ne eny injury or other traumatic event, the Madia Computer Service College (1-4or 5+) Elementary/Secondary (0-12) Senior Customer Serv.Rep Consulting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Matthias J.Pfeil Lula B.Bowser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
534 Fair Street, Ford City, PA. 16226 19a. Informant's Name/Relationship (Type, Print) 534 Fair Street, Matthias F.Pfeil/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 8/02/06 Chesapeake Crem. Beltsville, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Consee PHILIPADS: RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hepatic Failure Physician weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hemachromatosis years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Myelo Dysplastic Syndrome years physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 🖾 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42452 August 2,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chitra Rajagopal MD 18111 Prince Philip Dr. Olney, Md 20832 82. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 2 2006 Registrar

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Warren Lee Porter 1- For State Certificate of Death Reg No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Porter Lee 0057 hrs **Medical Examiner** Warren July 27, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NA Baltimore St. Agnes Hospital Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral Foreign Country) Months Days Min Director Hours 06-02-1982 Md. 1X M 2 F Yrs 219-98-8580 24 Usual Residence of Decedent 10d Inside City Limits any 10a. State 10b County 10c. City. Town or Location or items 23a or 28a-f show must be notified at once. 1 X Yes 2 No Baltimore Md. NA Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyggene ant. If I fear 27 is marked other than "natural", or items 23a or 28a-f she rother tranuarie event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country USA 21212 911 Lenton Avenue Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes Specif Black Yes, Give Year 1 Yes 2 X No specify: Widowed Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Unemployed NA llth grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carter Catina Be Porter, Sr. Lee Warren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catina Porter Mother 911 Lenton Avenue, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date X Burial 2 Cremation 3 Removal from State crematory or other place) permit Pages
Department of
Important: If
injury or othe 8-4-06 Randallstown, Md. King Mem. Pk. Donation 5 Other Specify Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure List only one cause on each line /Medical Death a. Gunshot wound to head Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last w pue Due to (or as a consequence of) The law requires that the death certificate be executed Physician/Medical attending physician are for use as the burial - t UNPENDED AMENDED item#28f,perME,g859,9/1/2006 TT Division of Vital Records, P.O. Box 68760, IF FEMALE 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: Be examiner? Other₄ DOA 1 / Inpatient 2 Nursing Home 5 Residence 6 this (ER/Outpatient 3 Other 1 🗸 Yes 28a Date of Injury (Month, Day Year) Jul 26, 2006 28d. Describe how injury occurred 28c. Injury at Work? Manner of Death Certification: Subject was shot 1551 hrs Natural Yes 2 V No 5 Pending Director: d in by the f within 24 hours after death. Accident Investigation 28f. Location (Street_and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) Landsdowne MD 2910 Lake Brook Circle Apartment 201 Landsdo determined (Specify) Multi-Family Apt. 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 27, 2006 rassel 6 Ma 10 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD 31. Date filed (Month, Day, Year) State 0

Registra

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Ub Certificate of Death Reg. No.-2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9:30 PM Lillie Charlotte Purcell Tul 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Keswick Multi-Care Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months Davs Hours Min. 1 - M XXF 89 Director 213-09-9812 Sep. 1,1916 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or iteme 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified at XXves 2 □ No MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3539 Keswick Rd. 21211 U.S.A. Completed by Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Item any injury or other traumette event, the Madical Examinations. ☐ Yes 2/☐/No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes XXNo Baltimore, Maryland 21215-0036 Specify Specify: White 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jerimiah Mechalske Leard Rose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charlotte Carol Grice/Daug. 3539 Keswick Rd. Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place)
Driud Ridge 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 8/3/06 Pikesville, MD Cemetery

22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature F neral Service License 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Opset and Death Immediate Cause (Final gestive heart & arlive Physician 7 days disease or condition resulting in death) /Medical Examiner Schere migral S— uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The faw requires that the death certificate be executed 8 Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnap 3 Ectopic pregnancy Day in the past 12 mon ō 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 Willston atrial 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 1110 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10No 2 1 Tes this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification; After 1 Natural 5 Pending 1 Tes 2 No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier icai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier august 1,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET, BALTIMORE, MD 21211 TACTREGOR M. ISMELLE 700 W 40 % 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 2 2006 Registrar

				1 _ State	State of Marylar		ent of Health a	nd Mental F	200	6 24216
				Registrar Decedent's Name (First, Middle, Last)		Oorane	ale or beaut	2. Date of	_	3. Time of Death
_		Physicia /Medic Examin		TAMMIE	D. CL	ARK	PINKNEY	JUL	1 30 200	6 12:55 P.M
				4a. Facility Name (If not institution, give st	- 11	4b. (City, Town, or Location o	Death	4c. County of De	ath
				5. Social Security Number 6. Sex	1705 P10	Jast hirthday) If U	nder 1 Year If Under 2	MORE 24 Hrs. 8. Date of	Birth 9.8	irthplace (State or Foreign
		Funeral Director			M 250 F	Yrs. Mor			Day Year) 70 N	Country)
		D		Usual Residence of Decedent				7117-12	29171017	
		arylar show	<u>_</u>	10a. State 10b. County	10c. Gi	y, Town or Location		1- 1		10d. Inside City Limits 1
		s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	Funeral Director	10e, Street and Number	4	10	SALTIMO E. Zip Code	ORE C	10g. Citizen of What	
				(3219 MC811	DERRY STI		2/2	15	11.5	4
				11. Marital Status	2. Was Decedent Ever in U Armed Forces?		ecedent of Hispanic Original Specify Cuban, Mexican	gin? (Specify Yes or	No- 14. Race - An Black, Wh	nerican Indian,
2	36	or Ite	by Fu	1 ☐ Never Married 2 ☑ Married	1 □Yes 2 No If Yes, Give		es 212 No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	2 4 4 7 4
35	21215-0036	filed within 72 hours after Hygiene. Yther then "neturel", or ite ent, the Medical Examine	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a Decedent's	Usual Occupation		16b. Kind of Busines	DLACK
3	215	nin 72 In 'na Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give kind o	of work done during most OT use retired)	of working	Tob. Ning of Edulios	amaday
	21,	or the	Com	12+1GRADE		DAYC.	ARE PRO	VIDER	SELF-E	MPLOYED
C	Maryland	be file d oth	Be	17. Father's Name (First, Middle, Last)		tinou	18. Mothe	r's Name (First, Midd	dle, Maiden Sumame))
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_	5	s 1 and f Health item 27 other tr		20a. Method of Disposition	20b. F	Place of Disposition cemetery, crematory	(Name of	Date /	20c. Location - City	or Town, State
30	Ë	Page nent o int: If iry or		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	ESTERN.	STAR CEME!	8-05-06	CATONSVI	LLE MD.
>	Baltimore,	permit. Pages Department of the Important: If ite eny injury or or once.		21. Signature of Funeral Service License	10 Am	22. Nam	ne and Address of Facility	BROWN	IJR. FUNE	
July		Physician /Medical Examiner	Examiner		P U	1 27.	40 N. FUL	TON AVE	BALTO. 1	40.21217
				23a. Part1. Enter the disease, or compliced shock, or heart failure. List only one	ations that caused the deat e cause on each line.	h. Do not enter the	mode of dying, such as	cardiac or respirator	/ árrest,	Approximate Interval Between Onset and Death
				Immediate Cause (Final disease or condition resulting in death)	Breast					years
					Due to (or as a conseq	uence of):				•
				Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	uenca of):				
Ē		executed in and ial-transi		that initiated events C.						
ammile	60,	be exectan a		resulting in death) Last	Due to (or as a conseq	uence of):				
13	68760	licate be executed physician and sthe burial-transit	dlcal	d.						
		nding nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna				23d. Date of d	elivery
_	P.O. Box	death e atte	Icla	in the past 12 pronths? 1 □ Yes 2 🖾 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		oic pregnancy or (specify)		Month	Day Year
7	P.0	at the 1 by th etache	Phys	9 Unknowń						
2	Division of Vital Records, I	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	on: To Be Completed by Physician/Me	Part fl. Other significant conditions cont	nbuting to death but not res	ulting in the underly	ing cause given in Part I.		d tobacco use contribute □ Yes 2.127No 3.□1	to the cause of death? Probably 4 □Unknown
(,	<u> </u>
	Rec							pe	topsy prior to formed? death?	
	ta			25. Was case referred to medical			26 Place	of Death (Check onli		es 2 No
	Ž			examiner?	ospital: 1 Inpatient 2	ER/Outpatient 3			esidence 6 ⊠Other (Sp	pecify) hayi'v
	0			27. Manner of Death Manual 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describ	e how injury occurred	
	sio	ttendi death. stor: A	cati	2 Accident investigation 3 Suicide 6 Could not be	One Diese of leiter. At h	M			/Street and Number	2
	Divi	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Certification;	4 ☐ Homicide determined	building, etc. (Special	Injury - At home, farm, street, factory, office etc. (Specify) 28f. Location (Scity or Tov			(Street and Number or Rural Route Number, wn, State)	
				29a. Certifier (Check only) Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
				one)	and manner stated.					
		To To Son	1	29b. Signature and title of certifier	\sim		29c. License number		29d. Date signed (Mod	7_ OC)-6
		1		30. Name and address of person who con	nnleted cause of death (trop	n 23a) (Type Print)	y 70 / 0 /		3319 311	
		P		AALON CAANGO, V	m 6601 N.	Cherles	ST Born	ne no	29d. Date signed (Mol	
		Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	turo michi	N.			
		Regist	rar	AUG 0 2 200	JO PREME	Nº KATAN				

			1 - State of Market Registrer	Maryland / Department of Health and M Certificate of Death	2000 24211
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No. 2. Date of Death 3. Time of Death
	Physicia		Linda Purvis		July 30 2006 06034
}	/Medid Examin		4a. Facility Name (If not institution, give street and number	er) 4b. City, Town, or Location of Death	4c. County of Deeth
			ST. Thomas more		MD. P.G. County
	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday) If Under 1 Year If Under 24 Hfs. Months Days Hours Min.	8. Date of Birth 9. Birthplace (State or Foreign Country)
	Director	-	Usual Residence of Decedent	40	June 22,1966 Wash. DC
	yland		10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
	Ba-f s	ctor	D.C. N/A	Washington	¥ Yes 2 No
	with th	i Dire	3101- 35th Street, N	10f. Zip Code 20018	10g. Citizen of What Country? U.S.A.
	death ms 23	lera	11. Marital Status 12. Was Decede	ent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No- 14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Extraction or other traumatic avant.	by Funeral Director	Armed Force 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes ☑ If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date	1 ☐ Yes 2 ဩrNo Specify:	Rican, etc.) Black, White, etc. Specify: Black
21215-0036	thour stural		15. Decedent's Education	16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
212	hin 72	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c	(Give kind of work done during most of work life. DO NOT use retired)	
	ed wit ygjene ar tha t, the	Con	12th	Unemployed	N/A
Maryland	d be fill ental H ted oth	Be	17. Father's Name (First, Middle, Last) James E. Purvis		e (First, Middle, Maiden Sumame) Line Rich
aryl	shoul and Me s mark umati	ို	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Run	al Route Number, City or Town, State, Zip Code)
	and 2 ealth a m 27 is		Anita Purvis/Sister	3101- 35th St., N.E	The second secon
nore	ages 1 ant of H t: If ita y or ot		20a. Method of Disposition 1	cemetery, crematory or other place)	20c. Location - City or Town, State 8/06 Wash., D.C.
Baltimore,	permit. P Departme Importan any injur		21. Signatury of Funeral Service License-		8/06 Wash., D.C. eral Chapel, Inc.
8	88 58		figetta w. Hacker	814- Upshur St	reet, N.W.
	Pnysician		shock or heart failure. List only one cause on each	sed the death. Do not enter the mode of dying, such as cardiac h line. Immunude AFENCY VINVS	Interval Between
	/Medical Examiner		3.0 (6.	as a consequence of):	9-4/10
	Examiner	iner	Sequentially list conditions, Tarry, leading to immediate cause. Enter Underlying	as a consequence of): as a consequence of):	7 47.03
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,09	Examiner	al Examiner	Sequentially list conditions, and the sequentially list conditions, and the sequential s	as a someoquemen org.	
68760,	Examiner	dical	Sequentially list conditions, and the sequentially list conditions, and the sequential s	as a consequence of):	
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			For State Registrar	State of Maryland /	Department of Health and N Certificate of Death	lental Hygie Reg.		24218
			Decedent's Name (First, Middle, Las	t)		2. Date of Death		3. Time of Death
	Physicia /Medic		DANIEL PARK	S		July July	30 2006	11:45 AM
	Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	_	4c. County of Death	
			HARBOR HOSPI		BALTIMORE birthday) II Under 1 Year II Under 24 Hrs.	8. Date of Birth	D T P	<u> </u>
	Funeral Director		5. Social Security Number 6. Sec. 215 - 52 - 3865	7. Age (In yrs. last i	Yrs. Months Days Hours Min.	(Month, Day, Ye	1948 P	nplace (State or Foreign untry)
			Usual Residence of Decedent			10 20	1410 //	
	irylan show	_	10a. State 10b. County and a	10c. City, To	own or Location	- A		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-1	Director		C	Hen Beun		. Citizen of What Cou	
	death with the Maryland ma 23a or 28a-f ahow rreast be notified at	Dir	10e. Street and Number 1355 Full	naco Brand	21060	109	/) C	.A
	deeth me 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No-	14. Race - Amer Black, White	
	72 hours after natural, or ita dical Examina		1 Never Married 2 Married	Armed Forces?/ 1 ☐ Yes 2 ☐ No If Yes, Gîve	1 Yes 2 No Specify:	rican, etc./	Specify:	INTE
5-0036	hours tural,	d by	3 Widowed 4 □ Divorced	Year or Dates:	Sa. Decedent's Usual Occupation	161	b. Kind of Business/I	ndustry
7	in 72	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give kind of work done during most of work life. DO NOT use retired)	ing		ndustry
717	s within piene. r than "	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Disab	led	NIA	
and	e filed at Hygid other vent, ii	Bec	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Mai	iden Sumame)	
<u>a</u>	Menta Menta arked	10			UniCanin			unkary
Mary	2 sho		19a. Informant's Name/Relationship (ypo, Print) 1 - Step daughter	9b. Mailing Address (Street and Number or Rui			ip Code)
	s t end f Health item 27 other t		20a. Method of Disposition	20b. Place	of Disposition (Name of	Brookl.	Location - City or T	rown, State
altımore,	00-		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	tery, crematory or other place) Carnel Con 8-4-		Lundal	
	permit. Pag Depertment Important: I any injury o		21. Signature of uneral Sirvice lice	//	22. Name and Address of Facility 27			
ñ	Per Per Per Per Per Per Per Per Per Per		Sany 1 11 1	ml	Gan P. march	Reneral	Home Bu	eto. md. 21229
			23a. Part . Enter the disease, or com- shock or leart failure. List only	olications that caused the death. Done cause on each line.	o not enter the modelof dying, such as cardiac			Approximate Interval Between
and the same of	Physician		Immediate Pause (Final disease or condition	Gangrene	of the bowel			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequent				3
		_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a socretiquent	to off			_
	nsit	min	Cause (Disease or injury					
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8760	cate be executed physicien and cate transit	edical		d				
0			IF FEMALE:					
Box	death certific: e ettending pl d for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. Il yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death			23d. Date of deliver Month	very Day Year
o.	0 0 0	iysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	5 Cities (specify)			
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รื่อ	w requires been sign should be					1 🗆 Yes	2 □ No 3 □ Pro	bably 4 Dunknown
ပ္တ	aw re	piet				24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
Ĭ	The lay ate has page 2	Completed				performed	d? death?	2 No
ita I	Physician: The la ir this certificate ha oral director, page 2	Be (25. Was case referred to medical examiner?			th (Check only one)		
5	Physic this c	10	1 Yes 2 No				e 6 Other (Spec	ify)
u O	ding F h. After tuner	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	D. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division of Vital Records,	or Attanding siter death. Director: After in by the tune	ficat	3 Suicide 6 Could not b	28e. Place of Injury - At home			and Number or Rui	ral Route Number.
2	ial or Attanding Pt s effer death. al Director: After the ed in by the funeral	Certification:	4 Homicide	building, etc. (Specify)		City or Town, S	State)	
	To the Hospital within 24 hours e To the Funeral I completely filled		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowled	dge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur	and due to the caus	se(s) and manner as	stated.
	the H the F npfete	Medicai	one)	and manner stated.	-			
	or v Son	2	29b. Signature and title of certifier	PGY-1	29c. License number		Date signed (Month)	
	\cap		30. Name and address of person who			J	~3 \ 20 '	5006
	4		MAY AL AT		HOSPITAL 3001	S HANOV	ER STRE	EET, MD
	Sta	te	31. Date filed (Month, Day, Year)	32-Registrar's Signature				
	Regist	ar	AUG 0 2 200	16 Beauce As	Court !			

DHMH 17 Rev 1/2001

ORIGINAL

		1 = For State Registrar			of Marylar	nd / Dep		t of He	ealth ar		ental Hy		9	6 6	24219
	Physician	1. Decedent's Name		st)			DED	DEDO			2. Date of De Month	ath Day	Year	r	Time of Death
	/Medical		DANIEL		S	•	_	LBERG			JULY	3	200	60	2:35 AM
	Examiner								ocation of I			4c. 0	County of De		/A
	Eupoval	5. Social Security Nur	mber 6. Se	. OF /-	7. Age (In yrs.	last birthday		1 Year	If Under 24		8. Date of Bir	th	9.8		(State or Foreign
	Funeral Director	214-24-8	- E	M 2□F	77	Yrs.	Months	Days	Hours	Min.	16715	1928		Country)	MD
	D .	Usual Residence of D	Decedent 10b. County		10c C	ty, Town or L	ocation							10d In	side City Limits
	Aaryia		N/A		100.01		IMORE								Yes 2 □ No
	28a-	10e. Street and Numb				DALI	10f. Zip	Code				10g. Citize	en of What C	Country?	
	ath with the Marylar 23a or 28a-f ehow	111 HAML	ET HILL	ROAD #1	1405				21210					U	SA
S	within 72 hours after death with the Maryland sheel "natural; or itams 23s or 28s-f show the Modical Exertines mark to notified at monitored by Eumeral Director	11. Marital Status		Armed Fo	edent Ever in U	J.S. 13.	Was Dece	dent of Hisp cify Cuban,	panic Origir , Mexican, I	? (Spe Puerto I	cify Yes or No Rican, etc.))- 1	4. Race - Am Black, Wh		dian,
36	s afte	1 ☐ Never Married		1 □Yes If Yes, Gir Year or D	2 X No		1 🗆 Yes		Specify:				Specify:		HITE
AMIEL 21215-0036	within 72 hours after dei jiene. r than "natural", or itams the Middical Eseroliner in	3 7 7 1 2	5. Decedent's Ed	ucation		16a. Dece	dent's Usu	al Occupati	ion			16b. Kin	d of Busines	s/Industry	,
41 { 215	hin 72	(Specify	only highest gra	de completed) College (1		rk done du se retired)	ring most o	f workii	ng			Í	
	od wit			4	,	INVE	STOR						_ ESTA	TE	
an _	uid be filed within 72 hours after death with the Mar Mental Hygiene. Inked other than "natural", or itams 23a or 28a-fel atto event, the Mudical Exacilizations to notifina. To Re Commissed by Funeral Director	17. Father's Name (F				PERLI	BERG	1	IB. Mother's	Name	(First, Middle	, Maiden S	,	BRAI	TERMAN
` >	nit. Pages 1 and 2 should erment of Health and Mer ortant: If item 27 is marke injury or other treumatic	19a. Informant's Nam		• • • • •							/ Route Numb				
ਦਿK ਪ e, Mar	1 and Health In 27 Iher tr	20a. Method of Dispo	NOVAN /	MILE	20h					14	1405 -		ation - City o		
\$ \$	Pages nent of th int: If ite	1 X Burial 2	Cremation 3 🗆		State RF	Place of Disponentery, cre	matory or o	ther place)	ADE O		1/2006		NDALLS		
デタレ烙も Baltimore	permit. Page Depertment: Important: If eny injury or once.	21. Signature of Fund	Other (Specify		DL		2. Name ar				LEVIN				
THE B	eny eny	11/1/10/	WI /	mus	_						ROAD -				
		23a. Part1. Enter the shock, or heart	disease, r comp failure. List only	olications that con-	caused the dea								-547M		roximate val Between
	Physician	Immediate Cause (F disease or condition			SPINA				MPRE					Ons	et and Death
	/Medical Examiner	resulting in death)		Due to	(or as a consec	quence of):									
	ð.	Sequentially list cond	ditions,	b. SMA	(or as a consec	TLL c	-ARC	INON	14 0	F	THE	LUN	45	1	YEARS
	executed and and ital-transit	Sequentially list cond if any, leading to immore cause. Enter Underly Cause (Disease or in that initiated events	ying jury		(,,-									
oʻ	ysicien and some burial-transit	resulting in death) La	st	Due to	(or as a consec	quence of):									
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Division of Vital Records, P.O.	gned be del	Part II. Other signific				sulting in the u	inderlying o	ause given	in Part I.		23e. Did t	obacco us	e contribute	to the cau	use of death?
ord	w requir	AIRIAL	+16K	CILLAT	TION	<u>-</u>				_	10	Yes 2□	No 3	robably	4 Unknown
Sec.	e law has b	HYPER-	TENSIC	77						_	24a. Was autoj	osy	prior to	completi	ndings available on of cause of
<u>a</u>	certificate har rector, page			ANCE	R						1 ☐ Yes		death? 1 ☐ Ye	s 2004	No
ξ	hysician: his certific il director.	25. Was case referre examiner?	Ī	Hospital:	fnpatient 2□	SB/Outpatie	nt 3 00				Check only one 5 ☐ Resi		Other (Co		
٥	g Phy er this leral o				of Injury oth, Day Year)	28b. Time o		8c. Injury a Work?	at I I I I I I I I		8d. Describe			өспу)	
ior	tendin eath. or: Aff the fur	1 ☑Natural 2 ☐ Accident	5 Pending investigation		(a), Day 10a)	inquiy	М		s 2 No						
<u></u>	tal or Attending P rs after death. al Director: Atter ted in by the funeral of incompared in the funeral contilination.	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Place	e of Injury - At h ing, etc. <i>(Speci</i>	iome, farm, st	reet, factor	, office		2	28f. Location (City or To	Street and vn. State)	Number or F	Rural Rou	te Number,
	pital ours a erai D		Certifying Ph	veicien: To the	a boot of my kn	owledge dool	th nearestand	at the time	data and s	laca a	and due to the				
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this: completely filled in by the funeral director. Medical Certification: To	(Check only 2 one)	Medical Exam	niner: On the b	asis of examination stated.	ation and/or in	vestigation	, in my opir	nion, death	occurre	ed at the time,	date and p	lace, and du	e to the c	ause(s)
	within To th comp	29b. Signature and til	tle of certifier				290	. License r	number			29d. Date	signed (Mor	ith, Day,	Year)
			a Loo	KMAN	LAWAL	_ M.	D	RES	00	00)	07/	31/2	006	
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	State	LOOKMAN 31. Date filed (Month		H_ M.	legistrar's Sign.	SINA	1 1+0) SP17	TAL O	+	BALTI	MORE			
	Registrar	· ·	JG 0: 2 20		alues s	K A	and I								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 24220 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month *25* **Physician** July 1218 AM narlene /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Mary land Medical Center) niversity If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 20 F 47 Yrs. Director 213-78-2676 Usuel Residence of Decede with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir then "natural", or items 23e or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Silver Spring MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20901 U.S.A. 211 Thistle Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mentai Hygiene. Int: if item 27 ie marked other then "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: ģ Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) MD National Bank Bank Teller 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice L. Brown Mead C. Palmer III 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 Thistle Drive, Silver Spring, Md 20901 Alice L. Palmer-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of important: if eny injury or once. Metro Crematory, Inc 8/1/06 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 23a. Part. Enter he disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he it dilure. List only one cause on the line.

Immediate Cause (Final disease or condition resulting in death)

a. Myo Cardial Infarction 21215 4300 Wabash Ave, Baltimore, Mo Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of): Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown the 9 Unknown sete has been signed by a page 2 should be detect 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? this certificete 1 Yes 2 □ No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a To the Funerel t 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Dey, Year) 29b. Signative and title of certifier 29c. License numbe 25; of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause Baltimore, MO James D -ampagna Greene 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 0 2 2006 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		artment of F rtificate of			iene	06	24221
			1. Decedent's Name (First, Middle, Last,					2. Date of Deat		Voor	3. Time of Death
П	Physici		Alice	Ryan				Month	3 / C	Year ∑⊌	2: 25pM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deat	h	4c. County		
		•	Charlestown Assist	ed Living		Catonsv	1110		Roll-	timor	.0
	Funeral		5. Social Security Number 6. Set	7. Age (In yrs	. last birthday)	If Under 1 Year					lace (State or Foreign
	Director		216-05-8303	M 2⊠F 104	Yrs.	Months Days	Hours Min.	Dec. 27	, 1901	Tex	
	9		Usual Residence of Decedent								
	show	_	10a. State 10b. County	10c. C	ity, Town or Lo	ocation				1	0d. Inside City Limits 1 ☐ Yes 2 🖾 No
	9 M	cto	Maryland Baltimor	e C	atonsvi						
	ith th	Die.	10e. Street and Number			10f. Zip Code	000	1	0g. Citizen of \	What Cour	ntry?
	ath w	Ta	707 Maiden Choice				228		USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23e or 28s-f show any figury or other traumatic avent, the Modical Exeminar must be notified at ance.	by Funeral Director	11. Marital Status 1 □ Nøver Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in t Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Blad	e - Americ ck, White, /: Whi	
9	72 hg	Completed	15. Decedent's Edu (Specify only highest grad			dent's Usual Occup		dkina	16b. Kind of B	usin <i>e</i> ss/In	dustry
7	the G	ld l	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)				
7	od wi	Con	12		Tel	ephone R			Manufa		ng
힏	d of H	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, M		18)	
<u>ya</u>	Men Men arke	၉	Jacob Bilhartz					Wernette			
Maryland	2 sh and Is m	1 1	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street	and Number or Ri	ural Route Number,	City or Town,	State, Zip	Code)
~	and ealth m 27		Louis Weinkam, Sr.			Frederi	ck Road;	Catonsvi			
altimore,	Pages 1 ment of H tant: If ita jury or ot		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cometery, create w Cath	matory`or other plac edral	8/4/	′2006 Ba		e, Ma	aryland
Ball	Depertition of the population		21. Signature of Funeral Service Licens	991	2	2. Name and Addre Funeral	ss of Facility Sto Home of	erling As Catonsvil	hton So	chwab	Witzke
	₹0 E # 0		Democr	halyes	w	1630 Edm	ondson A	Catonsvil venue; Ca	tonsvi	lle,	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the dea ne cause on each line.	ath. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	End-5+	acol	Demen	tia.				Onset and Death
	/Medical		resulting in death)	Due to (or as a conse	quence of):						
	Examiner		Sequentially list conditions.	o		_					
	ii or	luei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quarina of):						
	ficate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to for so a conse						_	
9	oe ex		Tooling III double, 223.	Due to (or as a conse	iquence on:						
8760,	physic the t	dical		J						-	
9	ing p	Me	IF FEMALE:	0. 16	41000						
Вох	death certifi e ettending p et for use as	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1☐Live birth 2☐Fel	tal death 3	Ectopic pregnancy	4		23d. Da	te of delive inth	Pry Day Year
	that the death certified by the ettending of detached for use as	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at time of 9 Unknown	death 5L	Other (specify)					
P.O.	The law requires that the sie has been signed by th bage 2 should be detache	4	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause gry	en in Part I	23e. Did toh	acco use cont	ribute to th	ne cause of death?
Š	w requires that been signed to should be det	by	Anorexia		,	, and a subsection of the			s 2□No	3 ☐ Prob	
Ö	requ	etec	- More proc					-			
ec	hast hast ge 2 s	Completed						24a. Was as autops	y I	prior to co	psy findings available mpletion of cause of
Vital Records,		ပ္						1 ☐ Yes 2		death? I □ Yes	2□ No
₹	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	logoital:		0#		ath (Check only on	θ)		
	Physithis characteristics and dir	유	1 195 28 140		ER/Outpatie		4 Nursing I	fome 5 ☐ Reside			y)
Ē	ing f	o	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Wor		28d. Describe ho	w injury occur	rea	
Sic	Attending r death. ector: Atter by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	00 01 (4-1			Yes 2□No	204			75
Division of	or At	Certification;	4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)	reet, ractory, office		28f. Location (St. City or Town		er or Hura	u moute Number,
L	Hospital 24 hours e Funeral C	ŭ	29a. Certifier 1P Certifying Phy	vicing. To the heat of on the	and the state of the state of	h deniment of the tr	mai vigita mentrate e	s and document	medator 4		tar La
	To the Hospital or Attending Phwitin 24 hours effer death. To the Funeral Director: Affer th completely filled in by the funeral	edical	(Check only 2 Medical Exami	ner: On the basis of examination and manner stated.	nation and/or in	vestigation, in my o	ppinion, death occi	urred at the time, da	ate and place,	and due to	the cause(s)
	o tha ithin o the	Med	29b. Signature and title of certifier	and mailing Stated.		29c. Licens	se number	2	9d. Date signe	d (Month.	Day, Year)
	F 3 F 8		D. N	3 0.					- 1 -	1.	,,
,			plusen 6	enter 1	~N		377		+(3	1606	
	0		30. Name and address of person who co	ompleted cause of death (ite	em 23a) (Type, M/	Print)	,	e, Cortan	e: 111 -	8 = .	21224
	- 01	to	Deneen Bowliv 31. Date filed (Month, Day, Year)	32. Begistrar's Sign	nature	n CHOI	ca Lane	e Couran	SVIIVA	m	121226
	Sta Registi				H A	ast!					
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ORIGINAL

		•	For State Registrar	State of Ma		epartment of H Certificate of L			giene 0 0	6 24222
			1. Decedent's Name (First, Middle, La	st)	D.			2. Date of Dea Month	ath Day Ye	3. Time of Death
	Physicia /Medic		Howard		Kees	se		July	29 20	Ob 3:10 P M
	Examin		4a. Facility Name (If not institution, given				Location of Death	1	4c. County of [
			19120 Muncaster 5. Social Security Number 6.5		(In yrs. last birth	Derwood	If Under 24 Hrs.	8. Date of Birth	Montgo	DMCTY Birthplace (State or Foreign
п	Funeral Director		125-09-7641	M 2□F	88 Yr	Months Days	Hours Min.	(Month, Day	Year	Country) Maryland
		1	Usual Residence of Decedent					1-1-1-	,	
	nylan how		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits 1 ☐ Yes 2 📉 No
	Ba-f s	Director	MD Montgon	nery	Derwoo					
	vith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	a 23a	eral	19120 Muncaster	Road	iver in U.S.	20850 13. Was Decedent of H	ispanic Origin? (Sc	ecify Yes or No-	USA 14. Race - /	American Indian,
36	ges 1 and 2 should be liled within 72 hours alter death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic avent, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 13€ Yes 2 □ N If Yes, Give		If Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)		Vhite, etc.
21215-0036	hour fural	ed b	15. Decedent's E	Year or Dates:	16a. D	Decedent's Usual Occupa	ation		16b. Kind of Busin	
5	n na	Completed	(Specify only highest gr			Give kind of work done of ife. DO NOT use retired	during most of world)	ing		
212	d with	E	Elementary/Secondary (0-12) 12	5+	res	earch Analy	rst		Dept. o	f Defense
pu	al Hygi I other	BeC	17, Father's Name (First, Middle, Las.	")					Maiden Sumame)	
yla	S should be filed within and Mental Hygiene. is marked other then aumatic avent, the Me	2	Harry Reese					Schauml		
Maryland	dand rand		19a. Informant's Name/Relationship			Mailing Address (Street				te, Zip Code)
	1 and Health am 27 ther t	1	Marshall H. Rees	se - Son	20b. Place of D	Devoe Stre		Lyn, NY_	IIIII	or Town, State
nor	ages int of t: # it y or o		1 ☐ Burial 2 🛣 Cremation 3 ['4 ☐ Donation 5 ☐ Other (Special Control of Co		1	crematory or other place		4, 06	Baltimor	a MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tra ance.	1	21. Signature Funeral Service Lice		recto	22 Name and Address	ss of Facility			
Ö	Depar Impo		hum x	Melas	19x	Cremation 299 Freder	cick Road	Raltimo	ore MD 2	
			23a. Part L Enter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each l	death. Do no	t enter the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Asi	pirat		neomi			Onset and Death 2 Qay S
	/Medical Examiner		resulting in death)	Due to for as	consequence of		16006			10
	Examine:	7	Sequentially list conditions,	b. Due to (or as a	CONSEQUENCE OF		us eas	<u>e</u>		10 91
	De X	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	545 (5, 45, 45,		,-)
Ć.	execu in and ial-tra	Exal	that initiated events resulting in death) Last	Due to (or as a	consequence of):			······································	
8760,	cate be executed physician and X. the burial-transit	dicai	•	€d						
9	ntifica ng ph s as th	Med	IF FEMALE:							
Вох	death certific e attending p id for use as i	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal death	3 Ectopic pregnancy			23d. Date of Month	delivery Day Year
0	0 0 0	ysic	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 ☐ Other (specify)				
م	requires that the di een signed by the hould be detached		Part II. Other significant conditions	contributing to death bu	it not resulting in t	the underlying cause give	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
ds,	luires that n signed t	d by	Hyper	ension				1 🗆 Y	′es 2	Probably 4 Unknown
of Vital Record	>	ompieted	. 71					24a. Was a		e autopsy findings available
Re	o	mo							rmed? deat	to completion of cause of h? Yes 2 \sum No
ital	sician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Dea			
<u></u>	69	To	examiner? 1 □ Yes 2 ☑ No	Hospital: 1 🗆 Inpatie			4 Nursing H	ome 5 esid		Specify)
n c	ing P	ion:	27. Manyler of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Tii Yeer) lnj	ury Wor	k?	28d. Describe h	now injury occurred	
Sio	Attending r death. Actor: Alter by the fune	icat	2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not		inv - At home farr		Yes 2 □No	28f. Location (S	Street end Number o	r Rural Route Number,
Division	or of the or	Certification:	4 ☐ Homicide determine	building, etc	c. (Specify)	n, street, factory, office		City or Tow		Transit Transit Transit
	Hospit 4 hour Funera	edical C			examination and	death occurred at the tin for investigation, in my o				
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (N	
)	. , , ,		DLVX)			HOD	54337	.	JUL	30,200
ĵ	241		30. Name and address of person who	completed cause of de	eath (Item 23a) (T	ype, Print)		(- 1 . 1	0.1	30,200, MD 21797
1	α'		Dr. Kichard	Stetunaci	e 20.	3250 Star	ting Gat	e Ct W	oodbine 1	no 21797
	Sta Regist		31. Date filed (Month, Day, Yeer) AUG 0 2 2	006 32 Tegistra	ar's Signature	Practi s				
				- CA 670.0		A Drug - Share				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year al OA M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Place at Pine wood Esthers Baltimore
If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F Director 216-01-1757 10/07/1914 Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, the Mudical Examiner must be nutified at 1 Yes 2 □ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itame 23a 321 S. Duncan Street 21231 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: 3 Widowed 4 □ Divorced "natural", White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed with and Mental Hygien 7 is marked other th Book Binder 6 Printing Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ည John Wieczynski Anastasia Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any injury or other traum <u>once.</u> Anita Rauh - Daughter 321 S. Duncan Street Baltimore, Maryland 21231 20b. Place of Disposition (Name of cemetery, crematory or other place)
Saint Stanislaus 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cemetery

22. Name and Address of Facility
David J. Weber Funeral Homes P.A.

401 S. Chester Street Baltimore, Maryland 21231

Approximate Interval Between Onset and Death Onset and Death * 4 ☐ Donation 5 ☐ Other (Specify) 08/02/2006 Baltimore, Maryland 21. Sign tu e of Funera Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Enysician Cardiac minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Myocardia minutes Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit The taw requires that the death certificate be executed VEUSS Coronary that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by i Yes 2 □ No 3 □ Probably 4 □Unknown Completed 24a. Was an autopsy performed? eriphera 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No er tension 2 No h Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Wither (Specify) Hospice 2 1 Inpatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of Death 1 Watural Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brock Seamer Hopkins Bayview Corde 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 0 2 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 24224 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Jeanette Steel
Facility Name (If not institution, give street and number) 07 28 06 10:30 A Steele /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Casey House If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Alabama 80 260-22-6514 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Iteme 23a or 28a-f ehov Ite Medical Examinar must be notified at by Funeral Director Forestville 1 VYes 2 □ No Prince Georges 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? USA 20747 6514 Grafton Street fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Music Teacher Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nd Mental } Pages 1 and 2 should be Willis Sconiers Nellie Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If Item 27 le any Injury or other traione. 25415 Damascus Park Terr. Damascus, MD. 20872 Shannon Smith/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Demoval from State Cedar Hill Cem. 08-05-06 4 ☐ Donation 5 ☐ Other (Specify) Suitland. MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MArshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. mais Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pancreatic Cancer Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disa to for as a consequence of Examiner Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? this certificate has autopsy performed? 1 Tes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only on Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSpice 1 ☐ Yes 2 反 No 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred N or Attending P s after death. I Director: After 1 Natural 2 Accident 5 Pending Injury 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 🗶 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical npletely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cynthia M Dilliams, Do H0058032 07-28-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CYNTHAM WILLIAMS, D.O. Montgomery HOSPICE GOOI MUNCASTER MILL Rd Rockville, MD 20852

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 2 2006

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 337 PM Strazzullo 00150 30 2006 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 719 Maiden Choice Lane #219 St. Charles 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Baltimore Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F Yrs Director 025-05-2888 92 02/17/1914 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "neturel", or items 23a or 28a-f show traumatic event, the Madical Examinator matter notified at 1 ☐ Yes 2 ☑ No Maryland Baltimore Catonsville Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 719 Maiden Choice Lane #219 St. Charles 21228 United States death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other than "neturet," or iten eny injury or other traumatic event, the Medical Exemples ones. 1 ☐ Yes 212 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: Specify: Caucasian 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker N/A Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jennie Zanti Salvatore Tringali 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 19a, Informant's Name/Relationship (Type, Print) Gail Marshall (Trustee) CMD-5023 120 E. Baltimore St. 23rdF Baltimore, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State * 4 □Donation 5 □ Other (Specify) Lorraine Park 08/03/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Procumonio /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cause Cause of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine 10 The law requires that the death certificate be executed the burial-transit the attending physician and Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ፭ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> Smoker 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? 1 ☐ Yes 2 ☐ No Division of Vital within 24 hours after death.

To the Funerel Director: After this certified completely filled in by the funeral director, I Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: P 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Leath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: o the Hospital or Attending 1 Natural
2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 30989 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date iled (Month, Day, Year) Maiden Choice Ln Outopoville MD Carpenter 32 Registrar's Signature State AUG 0 2 2005 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene 2 0 0 0

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inyland show	1	Usual Residence of Decedor Oa. State 10b. 0	ent County		10c. City, To								10d. Inside City Limits
r 188-f s		MD Oe. Street and Number	NA			Balti	more 10f. Zip Code			10g.	Citizen of W	Vhat Cou	
permit. Pages 1 and 2 should be filed within 72 hours after death with the maryland Department of Health and Menial Hygiene. Department of Health and Menial Hygiene. Important: If then 27 Is marked other than "natural", or items 23a or 28a-f show eny injury or other treumstic event, the Medical Example in must be notified at once. To Be Completed by Funeral Director	3	3012 Belmo	12	2. Was Decedent E Armed Forces? 1 □ Yes 2 ₺ N		13.	21216 Was Decedent of H		in? (Specify Yes Puerto Rican, et	or No- c.)		e - Ameri k, White	ican Indian, , etc.
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th and h		19a. Informant's Name/Re Dairen Scipi					ng Address (Street Belmont Ave				ty or Town,	State, Zi	p Code)
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Department of I		21. Signature of Funeral S	ervice License	us.	121110		2. Name and Addre	ss of Facility		Funer	al Home	P.A.	
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To the Hospital or Attending Physician: The law within 24 burus after death. with a Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2: Madical Certification: To Be Compl	ertilication	2 Accident	Pending investigation Could not be determined	(Month, Day 28e. Place of Inju- building, etc	ury - At home,	Injury , farm, st	M 1 reet, factory, office	rk? Yes 2 □ N	28f. Loca	ation (Stree or Town, S	t and Numb tate)	er or Ru	ral Route Number,
the Funeral Dir the Funeral Dir mpletely filled in I	Medical	29a. Certifier 1X (Check only one)	ertifying Phys ledical Examin	ician: To the best of er: On the basis of and manner sta	examination	dge, deat and/or in	th occurred at the ti	me, date and opinion, deat	d place, and due h occurred at the	to the caus time, date	e(s) and ma and place,	inner as and due	stated. to the cause(s)
To the compl	Me	29b. Signature and title o		Fano	ika 1	1D	29c. Licen:	se number	DO	29d.	Date signed	d (Month	2006
State		30. Name and address of MIH 0 TAN 31. Date filed (Month, Da	AKA	600 NOX		OLF	Print) ESTRE	et J	BALTIM	OPE,	MD	2	1287

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 6:35PM **Physician** Mary Ruth Shrader 2006 TUL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Agnes noopitat Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 30,1926 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☐ M 2 🗓 F Pennsylvania 80 Director 198 22 3480 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Baltimore Directo Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō U.S. 4 238 € 21227 4100 Maple Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 Married ō 1 Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retired Religious Sister Religious Sister 12th is 1 and 2 should be filed in the standard Hygie item 27 is marked other other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Susan Shambora John Paul Shrader 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sister Mary Becker 4100 Maple Avenue Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Depertment of H Important: if iten any injury or ott pncs. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland New Cathedral Cem. 8/4/2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of June al Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IRO **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) to the Hospital or Attending Physician: The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown been si 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No penormed? 1□ Yes 2☑ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Inpatient 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA ဥ this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: t Matural 2 Accident 5 Pending investigation t ☐ Yes 2 ☐ No death. Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 31. Date filed (Month, Day, Year) AUG 0 2 2006

30. Name and advess of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Ammer

BeKeLe 900 CATON 22. Registrar's Signature

Avenue BAITO

SHRADE

Maryland

Baltimore,

O. Box 68760,

Records, P.

		•	For State Registrar		State of Ma	ryland / I		iment of H ficate of L			giene Reg. No.	1006	24228
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			5. Social Security Number	GUATE 6. Sex	HUSDITC	(In yrs. last bit	rthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th 2	9. Bir	tholace (State or Foreign
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<u>.</u>	he de the e	ysic	1 ☐ Yes 2 No 9 ☐ Unknown		4 ☐ Pregnant at 9 ☐ Unknown	time or death	2 🗆 0	Other (specify)					
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ā	s efte s efte el Dira	Certification:	4 Homicide		building, etc	;. (Ѕреспу)				City of 10	wn, State)		
	To the Hospitel or Attending Physicien: within 24 hours effer deeth. To the Funeral Director: Affer this certific completely filled in by the funeral director,		(Check only 2 1	Certifying Phys Aedical Exami	sician To the best oner: On the basis of	examination a	ga death a nd/or inves	stigation, in my o	na, date and placa pinion, death occu	and due to the red at the time,	date and p	end manner a place, and du	stated e to the cause(s)
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		For State Registrar	State of N	Marylan				ealth and D <i>eath</i>	Mental H	ygien Reg. N	4000	2422	29
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/Medic Examin			anor	ar) Age (In yrs. I	last hirthday)	Pr	, Town, or	Location of Dea	ne		Som		omian
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1215-0036 within 72 hours after death with the Maryland ene. see. Then "naturel", or Items 23s or 28s-f show the modified at the Modified at the modified at t	by Funerai	5861 Brook Street 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give	s? X ^{No}		f Yes, sp	edent of H ecify Cuba 212 No	21804 ispanic Origin? (n, Mexican, Pue Specity:	(Specify Yes or Nerto Rican, etc.)	10-	U.S.A 14. Race - An Black, Wh	nerican Indian,	
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ds, P.O. uires that the designed by the id be detached		Part II. Other significant conditions	contributing to deat	h but not resi	ulting in the u	nderlying	cause giv	en in Part I.			o use contribute	to the cause of deal	
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Division of Vital Records, or Attending Physician: The law requires that death. Director: Attenthis certificate has been signed in by the funeral director, page 2 should be.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manyer of Death 1 Natural 5 Pending	Hospital: 1 Inp		ER/Outpatier 28b. Time of Injury		28c. Injur Wor	er: 4 Nursing	eath (Check only Home 5 Re 28d. Describe	sidence	6 ☐Other (Sp jury occurred	pecify)	
Division of the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funeral c	Certification:	2 Accident 3 Suicide 4 Homicide investigati 6 Could not determine	be 28e. Place of	Injury - At ho	ome, farm, str	M eet, facto		Yes 2 □ No	28f. Location City or T			Rural Route Number	r.
DIV To the Hospital or A within 24 hours affer To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exi	Physician: To the beaminer: On the basis	s of examina	wledge, death tion and/or in	n occurre vestigation	d at the tin	ne, date and pla- pinion, death oc	ce, and due to th curred at the time	e cause e, date a	(s) and manner and place, and d	as stated. ue to the cause(s)	
To the To the complet	Me	29b. Signature and title of certifier				2	9c. Licens	e number 4 709 4		29d. E	Date signed (Mo	nth, Day, Year)	
6		30. Name and address of person wh	o completed cause of	of death (Item	1 23a) (Type,	Print)	15102	STRIF	SKUSB	Aij	MD:	21804	
	ate rar	31. Date filed (Month, Day, Year) AUG 0 2 20		istrar's Sign	ture	de							

Please Type or Print in Black Indelible Ink

Maryland / Department of Health and Mental Hygiene

Santini Stanfield		ryland / Departn			giene	5 6 4	
	1- For State	Certifi	cate of Death		Reg.	No 200	6 2423
Physician/	1. Decedent's Name (First, Middle,Last)				2. Date of Death Month D	ay Year	3. Time of Death
Medical Examine	2/1/4/1/1/	TONY.	- 1 - 17	IELD	July 29, 200		1324 hrs
	4a. Facility Name (if not institution, give street at 1000 block Booth Street	nd number)	4b. City, Tov	wn, or Location of Death		4c County of Death	10
	5 Social Security Number 6. Sex	7. Age (In yrs. last b			8. Date of Birth(I	MM/DD/YYYY) 9. Birt	hplace (State or
Funeral Director	215-91-4483 1XM 2	11	Yrs. Months	Days Hours Min.	day it	1 10 79 Foreign	n intry)MARI/I in IA
	Usual Residence of Decedent	J CX Y	7 113.		11000	7,11,11	TIMINYZINB
auy	10a. State 10b. County	10c. City, Tow	vn or Location		0		10d. Inside City Limits
death with the Maryland or items 23a or 28a-f show must be notified at once.	MARYLAND N/A		BAL	TIMORE	CIT	7/	1 Yes 2 No
the Maryland a or 28a-f sh tified at once	10e. Street and Number	10.	10f. Zip C	ode	10g.	kitizen of What Cour	try?
the the Sa or notifie	1 01 /1/12/11-0		NUE	01/22	3 _	USA	La Ladina Blook
r death with or items 23		s Decedent Ever in U.S. ned Forces?		of Hispanic Origin? (Spe Cuban, Mexican, Puerto I		14. Race - Ameri White, etc.	can indian, black,
or dear	3 Widowed 4 Divorced If Yes Gi	Yes 2 No	1 Yes 2	No specify:		Specify: 13	IACK
urs aftı tural" amine	or Dates:		a. Decedent's Usual O	ccupation (Give kind of w	ork done	6b. Kind of Business/I	ndustry
72 hor mana al Exa	Elementary/Secondary (0-12) Colle	ege (1-4 or 5+)		ng life. DO NOT use retir	ed)	\sim	0
5-0036 led within 72 hour Hygiene t other than "natu the Medical Exan	11+ GRADE		K001	FING		KOOFING	3 COMPANY
15-0 illed w Hygin d other		C	1000	18,Mother's Name	(First, Middle, Mai	iden Surname)	esal
Baltimore, MD 21215-0036 pennit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menfal Hygien and Department of Health and Menfal Hygien in Handra in San of Saar She important: If item 27 is marked other than "natural", or items 23a or 28ar she injury or other traumatic event, the Medical Examiner must be notified at once To Re Completed by Funeral Director		31A	19b. Mailing Address	(Street and Number or R	ural Route Numbe	er, City or Town, State	, Zip Code)
MD 21 the 2 should alth and Me m 27 is ma aumatic even	ANNIE STANFIELD	(MOTHER)	195. A	RLINGTO	NAVE.	BALTO. 1	10.21223
and 2 and 2 and 2 licem 3 item 3	20a. Method of Disposition	20b. Plac	e of Disposition (Name natory or other place)		Date / 2	20c. Location - City or	Town, State
caltimore,				METERY08-	13-06	BAITING	RE MA.
altin nii P Bartme Doutan	4 Donation 5 Other Specify 21 Signature of Funeral Service Licensee	3'11'	22. Name and A	ddress of Fac. ty	PAUX TI	R. FUNER.	AL HOME
in III Dept	withich N. V.	Villiam	0 3178	N. FULTE	NAVE.	BALTO. M	D. 21217
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/Medical Examiner		e Gunshot Wounds					Death
		or as a consequence of):					
	Sequentially list conditions, if any, leading to immediate Due to (0	or as a consequence of):					
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ੰ ਡਾਲ	UNPENDED AMEN	DED					
~ o .2.E 7	IF FEMALE: 23c. I	f yes, outcome of pregnan	ncy			23d Date of deliver	<u> </u>
Box 68760 e death certificate b the attending physic cd for use as the bu	23b Was decedent pregnant in the past 12 months?	Live birth	2 Fetal death	3 Ectopic pregna	ncy	Month I	Day Year
OX cath ce attent	1 Yes 2 No 9 Unknown	Pregnant at time of death Unknown	5 Other (Speci	fy)			
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ViSi or Ati or Ati or Ati or Ati	3 Suicide 6 Could not be	e. Place of Injury - At home	e, farm, street, factory,	office building, etc.	or Town, Sta	ite)	ural Route Number, City
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To the To the Comp		anner stated.		License number		29d. Date signed (Mo	
		14		O.C.M.E.		July 30, 2006	
7	30. Name and address of person who complete	ed eause of death (Item 23	Ba)				
N		Medical Examiner		t, Baltimore, MD 2	1201		
Sta	te 31. Date filed (Month, Day, Year)	32. Begistrar's Signature	medis				
Registr	AUG 0 2 2005	DEPENSE A.	19		_	· <u>-</u>	

State of Maryland / Department of Health and Mental Hygiene 006 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 30, 2006 **₹:00 €**M SAHAK SHAHVERDIAN 3064 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner JUNDAA UNA GLEN BURNIE AB THBD JADIOSH HOTOHINGAW SAOM ITJAB Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F 85 Yrs. 219-43-5993 1921 Iran Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 XNo Maryland Anne Arundel Geln Burnie Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21061 328 Highland Drive Iran Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. Body Shop Self Employed permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy important: if Itam 27 I e marked othe eny injury or other treumatic event, 9069. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Artoon Shahverdian Marnious 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 451 Geldale Ave., Glen Burnie, MD 21061 <u> Hilda Shahnazari (Daughter)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 8/2/06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY FAILURE 2 DAYS /Medical Due to (or as a consequence of): **Examiner** 20 YEARS SPASSIG PARMONALUS SVITSURTORO CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funarel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director name? Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 1 XYes 2 No 3 Probably 4 Unknown PITUSMED Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification; To 1 Tes 2 No 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 1 KNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide 1 🔀 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Chiesana J. Gion grow, MD D0067+1A JULY 30, 2006 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 HOSPITAL DRIVE, GLEH BURNIE, MD 21061 CIANGRECO GUILLERMO JOSE 31. Date filed (Month, Day, Year) 2. Registrar's Signature State market AUG 0 2 2006

Registrar

				1 - For State Registrar	State of M	larylan		artment o		d Mental Hy	giene Reg. No. (2006	2423
		Physici		1. Decedent's Name (First, Middle, Last) William D. St	emm Jr.					2. Date of De Month July	20ay	2006	3. Time of Death 8:35 AM
		/Medio Examir		4a. Fecility Name (If not institution, give s Stella Maris)			n, or Location of D	eath		ounty of Death Baltimon	:e
		Funeral Director		5. Social Security Number 6. Sex 219-32-5866	7. A	ge (In yrs. 1	ast birthday, Yrs.	If Under 1 Ye Months Da		Hrs. 8. Date of Bi Ain. (Month, D June 2		9. Birthp	lace (State or Foreig Itry) Land
		death with the Maryland ms 23a or 28a-f show rmust be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland N/A 10e. Street and Number		10c. City	Balt	imore	le		10g. Citize	n of What Cour	0d. Inside City Limits 1 XYes 2 ☐ No
		23a or	ai Di	3939 Roland Avenue	e, #5 1 6			2	1211		Ţ	USA	
а.п.	9036	urs atter al', or ite Exeπilie	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	2. Was Decedent Armed Forces 1 Tyes 2 The If Yes, Give Year or Dates:	? (No	S. 13.	Was Decedent If Yes, specify 0 1 ☐ Yes 2 🛣		? (Specify Yes or No uerto Rican, etc.)	1	Black, White,	etc.
8:35	21215-0036	filed within 72 hours after Hygiene. ither then "netural", or ite ont, tre Medical Εχαπίσε	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		5+)	(Ĝive life.	dent's Usual Oc kind of work do DO NOT use re chanic	cupation one during most of tired)	working		of Business/Ind actory	dustry
	d 2	a filed I Hygi other	Be Co	17. Father's Name (First, Middle, Last)		-			18. Mother's	Name (First, Middle			
2006	ylar	should be nd Mental marked c	To B	William D. Stemm					Jol	nanna A.	Hubert	t	
7(Maryland	12 sho h and 7 is m Iraum		19a. Informant's Name/Relationship (Ty)	•					r Rural Route Numb			•
Y 29,	altimore, I	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if tem 27 is marked other then "netur any injury or other traumatic event, tra Medical ance.		Betty A. Henson, 20a. Method of Disposition 1 □ Burial 2 【XCremation 3 □ R 4 □ Donation 5 □ Other (Specify)		, a	tace of Disperent of the terminal of the termi	west brongstion (Name of matory or other ematory)	place)	Dallas Date 7/31/06	20c. Loca	tion - City or To	
JULY	Balti	permit. Departminportal any inju		21. Signature of Funeral Service Censes Thomas Gregor	18	1				ty Of Mar bad Balti			
•	8760,	Physician /Medical Examiner behavior and Examiner transit sthe purial-transit	dicai Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a:	CANCER s a consequence s a consequence	uence of): uence of):						Interval Between Onset and Death
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WIL	ion of	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ation: To	27. Manner of Death 1 % Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D		28b. Time of Injury	f 28c. l	njury at Work? 1 Yes 2 No	28d. Describe			HUSFICE
	Divis	tef or Atters after de al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	njury - At ho atc. (Specify	ome, farm, st	reet, factory, off	ice		(Street and i wn, State)	Number or Rura	l Route Number,
		To the Hospitel or Attenc within 24 hours after dealt To the Funeral Director: completely filled in by the	Medicai	one)		of examinat		vestigation, in r	ny opinion, death o	lace, and due to the	date and p	lace, and due to	the cause(s)
		or Wilting	2	30. Name and address of person who co		death (Item	1 23a) (Type.	T	ense number)4772		7	8/31/00	
			ate	DR. TARIQ MAHMOOI	32 Pegis	trar's Signa	ture	LEY RD.	TIMONII	JM, MD 210	093		
	DH	Regist		AUG 0 2 200	O Stale	a l	K A	BAD!		5 -			

DHMH 17 Rev 1/2001

			1_ For State	State of M		Depart	ment of	Health and	-		_	
			Registrar 1. Decedent's Name (First, Middle,	Local		Ceni	ficate of	Death		Reg. N	o. L. UU	6 2423.
	Physic /Medi		Richard Craig	Slaysman					2. Date of D		200	3. Time of Death 6 2048 M
	Exami	ner	4a. Facility Name (If not institution,	give street and number,)	4	b. City, Town,	or Location of Dea	ath ()	4	c. County of De	ath
	Funcion		Upper Chesapea 5. Social Security Number		Center	hirthday	Bel .		S Q Date of B	i-th	Harfo	
	Funeral Director		219-56-3588		6	Yrs.	lonths Day:		n. (Month. D	av. Year	1949 Ma	irthplace (State or Foreign Country) Try Land
6	2		Usual Residence of Decedenl						- Indg.	27,	1747 114	Tyrand
80	arylar ehow	-	Md. Harfo	w.J	10c. City, To							10d. Inside City Limits
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_	er de	Funerai	11. Marital Status	12. Was Decedent Armed Forces	?	13. Wa	Decedent of es, specify Cu	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	0-	14. Race - Am Black, Wh	
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	d Mer mark natic	2	Jerry Slaysman					Marie				
	d 2 si th an t7 is r		19a. Informant's Name/Relationshi Susan Slaysman		11	9b. Mailing <i>A</i> 8813 E	ddress <i>(Stree</i>	tand Number or F Court, Al	Rural Route Numi pingdon.	Md.	or Town, State,	Zip Code)
(CO)	ges 1 and 2 should be filed within 72 hr to of Health and Mental Hygiene. If Ithm 27 is marked other than "natur or other traumatic event, its Micalcal		20a. Method of Disposition		20b, Place	of Disposition	on (Name of		Date		ocation - City o	r Town State
O E	Pege: ent of nt: If ry or		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe				ory or other place.		28/2006		ltimore	
MO19830 T	permit. Peges 1 and 2 should be filed will Department of Health and Mental Hygien Importent: If Item 27 is marked other then y injury or other traumatic event, ITE QREE.		21. Signature of Funeral Service Li									-
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			23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that caused	d the death. Do	o not enter t	ne mode of dy	ing, such as cardia	ac or respiratory	rrest,	r, Ma.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Ce	rebro	Vasc	ular	acci	dont			Onset and Death
	/Medical Examiner		resulting in death)		a consequenc				<u> </u>			J. E. P. D. C.
		7.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to for as	a consequence	Khr	iia		<u> </u>			45 mins.
	bed William	Examiner	Cause (Disease or injury	Due to (01 as	a consequenc	ر بور ق						
ó	te be executed ysicien and the burial-transit	Exa	that initiated events resulting in death) Last	C. Due to (or as	a consequence	e of):						
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hard Box 68	eath certificat attending phy for use as th	Med	IF FEMALF:									
cho.	ath cert attendin for use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Fetal dea	th 3□Ect	opic pregnanc	:v			23d. Date of de	· ·
	t the de by the a tached f	by Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of death	5□ Ot	ner (specify)		-		Month	Day Year
P.O.	res that If igned by be detac	, Ph	Part II. Other significant condition	s contributing to death b	ut not resulting	in the under	tving cause g	ven in Part I	23e Did	lohacco	use contribute to	o the cause of death?
rds,	The law requires that the death certificate to has been signed by the attending physoage 2 should be detached for use as the	D	diabetes no	ellitus e	1		renal	disease				robably
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Simo	The lav ate has page 2	mo.	2 Sur San	3, 11900		- 1114	-w Cri	5/1	auto	psy ormed?	prior to death?	completion of cause of
Sizal Sizal	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?					26. Place of De	1 ☐ Yes	2 No	1 Yes	2 No
3778	Physician: this certific al director,	ျ	1 ☐ Yes 2 No		ent 2 ER/C	outpatient :	DOA Ot		Home 5□Resi		6 □Other (Spe	ecify)
S uc	the factor	ertification:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year) 28b.	Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe			
S lo Division	Attendi death. ctor: A y the fu	icat	2 Accident investigat 3 Suicide 6 Could no	be	41.5]Yes 2 □No				
Λ !Ö	after Direct	ertif	4 ☐ Homicide determin	28e. Place of Injuding, etc	c. (Specify)	rarm, street,	factory, office		281. Location (City or To	Street ar wn, State	nd Number or Ai B)	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funarel Director: A completely filled in by the fu	aic	29a. Certifier 1 Certifying	Physician: To the best	of my knowledg	ge, death oc	curred at the t	me, date and plac	e, and due to the	cause(s	and manner as	stated
	in 24 in 24 ihe Fr	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner sta	r examination a	nd/or invest	galion, in my	opinion, death occ	urred at the time,	date and	place, and due	to the cause(s)
	or Test	2	29b. Signature and title of certifier				29c. Licen			29d. Da	le signed (Mont	h, Day, Year)
	. ^		Rete Harry					26402	5	JUL	7 25	2006
	4 /		30. Name and address of person wh	no completed cause of d	eath (Item 23a	(Type, Prin	t)	10 - 1		, ,	21014	, 2006 (LAN)
	Sta	te.	PETER HANNON 31. Date filed (Month, Day, Year)	32 Registre	ar's Signature	CHES	APEAI	ce driv	C, ROL	HIS	MARY	LAND
ė	Registr		AUG 0 2 2	006	w B.	Jose		ce driv				

			For Stata Registrar	State of Maryland		rtment of H tificate of I		-	giene Reg. No. 2006	24234
	Physici /Medic		Decedent's Name (First, Middle, Last) LUCILLE			SILVERS		2. Date of De Month JULY	30°, 2006 ear	3. Time of Death 6:50 P M
	Examir		4a. Facility Name (If not institution, give s HOSPICE OF BALTIMO		CTR.	4b. City, Town, or	Location of Di TOWS(4c. County of Dea BA	LTIMORE
2	Funeral Director		5. Social Security Number 6. Sex 220-24-1300	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 H	Ain. 8. Date of Bir	th 9. Bir	thplace (State or Foreign ountry) MD
	yland how		Usual Residence of Decedent 10a. State 10b. County		, Town or Lo					10d. Inside City Limits
	in the Ma or 28a-f a	Funeral Director	MD BALTIMO 10e. Street and Number		BALTI	MORE 10f. Zip Code			10g. Citizen of What Co	•
	death wi	neral C	7927 WINTERSET AV 11. Marital Status 1	ENUE 2. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Vas Decedent of H	21208	(Specify Yes or No uerto Rican, etc.)	14. Race - Am	
920	ours after rai', or ita Examina	þ	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 [] Yes 2 () No If Yes, Give Year or Dates:		Tes, specily Cuba	Specify:	derio nicari, etc.)	Black, Whi	WHITE
aryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28s-f show other traumatic avent, the Modical Examinal must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (p-12)	completed) College (1-4or 5+)	16a. Deced (Give life. I HOMEN	lent's Usual Occup kind of work done o DO NOT use retired INVFD	ation during most of t)	working	16b. Kind of Business OWN HOME	/Industry
Ind 21	be filed w ntal Hygier od other th avent, ID	Be	17. Father's Name (First, Middle, Last) JAMES		LECOM		18. Mother's	Name (First, Middle,		LOWMAN
laryla	2 should and Men Is marks sumatic	Ţ	19a. Informant's Name/Relationship (Typ		19b. Mailir	g Address (Street	and Number o	r Rural Route Numbe	er, City or Town, State,	Zip Code)
ore, N	es 1 and 3 of Health f Itam 27 ir other tr		STACEY RUBIN / DA 20a. Method of Disposition 1 X Burial 2 Cremation 3 Re	20b. Pf		sition (Name of natory or other place		Date	ORE, MD 212	
Baltimore,	Pag nent ant: I		4 Donation 5 Other (Specify) 21. Signature Juneral ervice Lice see	OHE	B SHAL	OM MEMOR Name and Addres	IAL 07/		REISTERSTON NSON & BROS	
eg B	permit. Depertr Imports any Inje		23a Part Fotor the disease or compile	ations that caused the death				WN ROAD -	PIKESVILLE	
14.4	Physician		23a. Part1. Enter the disease, or complite shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cada on each line. Breart (ance		•	,		Interval Between Onset and Death
	/Medical Examiner		Sequentially list conditions							
	acuted Ind X	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Cita to (or as a consequ						
8760,	licate be executed physician and street the burial-transit	dical Ex	Todaling in dealing code	Due to (or as a consequ	ence or):					
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Rec	The law ate has b page 2 sl	Completed	Chanic lun	g Discore				24a. Was autoj perfo 1 🗆 Yes	psy prior to death?	utopsy findings available completion of cause of s 2 No
Vita	ysician: The I is certificate ha director, page	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) H	ospital: 1 □ Inpatient 2 □ I	ER/Outpatier	it 3 DOA Oth	05	Death (Check only only only only only only only only		who was PIAE
Division of Vital Records,	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ation: T	27. Manner of Death 1 Natural 5 Pending 2 D Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor			how injury occurred	1070100
Divis	al or Atte s after des il Diracto	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (. City or To	Street and Number or R wn, State)	ural Route Number,
	e Hospit 124 hours a Funera (etely fille	edical (29a. Certifier (Check only one) 1 Cartifying Phys 2 Medical Examin	ician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or in	occurred at the tirvestigation, in my o	ne, date and pi pinion, death o	lace, and due to the occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the To the comp	Ň	29b. Signature and title of certifier	* 40.0		29c. Licens	e number		29d. Date signed (Mon	th. Day, Year)
,	12		30. Name of address of person who co		23а) (Туре,	Print)	3/31		July,	31,2006
	St.	at <u>e</u>	31. Date filed (Month, Day, Year)	32 Registrar's Signat	pper	cherapes	ite O	rive Be	LAW N	VD 51012
4	Regist		AUG 0 2 2006	Mary 18	Mary	1				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 206 28 /Medical 4c. County of Death City, Town, or Location of Death Facility Name (If not institution, give street and number) 4a. Examiner NA If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 12-12d. Sex 7. And (In yrs, last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours Min 1**∑** M 2□ F 214-62-8779 52 Director Md. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County r than "natural", or Itams 23a or 28a-f show the Modical Examiner must be notified at 1 X Yes 2 ☐ No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3039 Mayfield Avenue 21213 USA by Funerai death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2½ No If Yes, Give² Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married ♣☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Indoor groungs Maintenance Beth EL Congregation other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 8 Williams Ulysses Rosa Lee ပ Pages 1 and 2 should 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Sherri Williams Wife 3039 Mayfield Ave., Baltimore, Md. altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ö Department of Important: If eny injury or once. Holly Hills Cem. 8-4-06 Middle River, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 lady March F.H. East 1101 E. North Ave. n ome 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician netastatic 16 mouths disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit ando resulting in death) Last Due to (or as a consequence of): Box 68760, attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Tyes 2 5 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 s autopsy performed 1 ☐ Yes 2 🗆 Hospital or Attending Physician: funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural nours after death. nerel Director: Af filled in by the fur 1 🗌 Yes 2 🔲 No 2 🗋 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel C completely filled i 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sig ature DIRECTOR. MEDICAL ONCOLOUS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ross Wolfe St. Donahowa 600 Nonth 32 Registrar's Signature ear) State 0 Registrar

			1 = For State Regist <i>rar</i>	State of Ma	aryland /	-	rtmen tificate			and Me	ental Hy	giene Reg. No.	006	242	36
	Physici	an	1. Decedent's Name (First, Middle, Last)	1							2. Date of De Month	ath Day	Year	3. Time of	Death
	/Medic		Datry Willi	te							JULY_	30	2006	1:05	AM
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	Funeral Director		5. Social Security Number 213-30-5667 6. Sex 1 Usual Residence of Decedent		e (In yrs. last bi	Yrs.	Months	Days	Hours		8. Date of Bi • (Month, Di JUNE 9,		MARYI.		r i-oreign
	/land		10a. State 10b. County		10c. City, Tov	wn or Loc	cation						Ţ-	0d. Inside Cit	y Limits
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	or 28	Oire	10e. Street and Number				10f. Zip					10g. Citiz	en of What Coul	ntry?	
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21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene d other than "natural", or Itema 23a or 28a-f show event, the Medical Exertinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		11	Yas Deced Yes, spec	rify Cubai	spanic Origin, Mexican Specify:	gin7 (Spec i, Puerto F	cify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: B]		
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grade		16a		lent's Usua		ation during most	of workin	ıa	16b. Kir	d of Business/In	dustry	
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	Hygie ther t		17. Father's Name (First, Middle, Last)	NA		DOME	STIC		18. Mothe	r's Name	(First, Middle	1	OMES Sumame)		
ano		To Be	ROBERT CURE							R. S					
Maryland	d 2 shou th and M t7 is mar traumet	_	19a. Informant's Name/Relationship (Ty SHAWNTIA D. GRIFFIN G				-		and Numbe	r or Rural		-	Town, State, Zip D 21229	Code)	
re,	es 1 an of Heal fitem 2 r other		20a. Method of Disposition		20b. Place o	of Dispos	sition (Nan	ne of ther place	θ)	Da	ate	20c. Loc	ation - City or To	wn, State	
Baltimore,	Pages nent of ant: If its ary or o		1 Structural 2 □ Fernation 3 □ Hermoval from State 1 □ Donation 5 □ Other (Specify) MT. ZION CEMETERY							JG 3,	2006	LANSD	OWNE, MARY	T_AND	
alt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	90			_				IE FUNER				
Ш	20.5 20		23a. Part1. Enter the disease, or compli	mes									ND 21217	Approximate	
8760,	zate be executed // Medical Examiner // Application and // Application and // Application and // Application //	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence a consequence	e of):	chi		Arr	byl	Muic			Onset and D	eath
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	To the within To the	Me	29b. Signature and title of certifier				290	. License	number			29d. Date	signed (Month,	Day, Year)	
			1/Upodo	my fre				D C	4023	21		July	31,200	56	
V	2		30. Name and address of person who compared to the compared to	mplet d cause of d	eath (Item 23a)) (Туре, І	Print) 3	25	HOS EN B	PITT	42 D	RIVE	21061	E 20	8
	Sta Registi	ite ar	31. Date filed (Month, Day, Year) AUG 0 2 2	32. Registre	ar's Signature	16	back	,							

DHMH 17 Rev 1/2001

06-05506 Teon White

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		- For State	o or marylana / E	•	cate of				eg. No. 200	16 2423
Physician Medical Examine	-	Decedent's Name (First, Middle,L TEON WHITE	ast)					2. Date of Dea Month July 28, 2	Day Year	3. Time of Death 1232 hrs
	1	4a Facility Name (if not institution, of University of Maryland	give street and number)		4k	. City, Town, or Baltimore	Location o		4c. County of Deal	th
Funeral		5. Social Security Number 6.	Sex 7. Age (i	n yrs. last b	oirthday)	If Under 1 Year	_			orthplace (State or
Director			XM 2 F 25	5	Yrs.	Months Days	Hours	Min. FEB 23		ountry) MD
an.	-	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Tov	vn or Locatio	n				10d Inside City Limits
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215-0036 be filed within 72 hours after death with the Maryland nat Hygiene. rked other than "natural", or items 23a or 28a-f she cent, the Medical Examiner must be notified at once	Φl	10e. Street and Number 2024 BRADDISH AVENUE				10f. Zip Code 21216			USA	untry /
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after di	짉	- Land	1 Yes 2 X ed If Yes, Give Year or Dates:			res 2X No	, ,	_	Specify: BLAC	
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21215-0036 Id be filed within 7 Aental Hygiene event, the Medica	ပ္ကိ မ်ို့	17. Father's Name (First, Middle, La VICTOR WHITE	St)					NA ROBINSON	waden sumane)	
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cath certifications as a strending for use as	Physician	past 12 months? 1 Yes 2 No 9 Unkno	1 Live birth 4 Pregnant at tin	ne of death		er (Specify)	Loroph	o prognancy	Month	Day Year
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f Vita Physicia er dhis ce	10 B	examiner? 1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a Date of Injury		NOutpatient Bb. Time of In		Other ₄		Residence 6 Oth	er.
on of ending Pl ath. or: After he funera		1 Natural 5 Pendin	Jul 28, 2005		140 hrs		res 2	 ISubject wa 		
Divisior septial or Attend hours after death meral Director: y filled in by the	Certification:	2 Accident Investig 3 Suicide 6 Could r	28e. Place of Injur		e, farm, street	, factory, office b	ouilding, et	or Town,		Rural Route Number, City
		29a. Certifier (Check only 1 Certifying Physics)	sician: To the best of my k	nowledge,				ace, and due to the cau	ise(s) and manner as sta	arted.
To the Bo within 24 t To the Fu	Medical	one) 2 Medical Exami 29b. Signature and title of certifier	ner: On the basis of examinand manner stated.	nation and/	or investigati	29c. Licens		at the time, date	29d. Date signed (M	
			Ma MD.			O.C.	M.E.		July 29, 2006	
5		30. Name and address of person w Melissa Brassell, MD	ho completed cause of dea Assistant Medical E			enn Street, E	Baltimor	e, MD 21201		
Sta		31. Date filed (Month, Day, Year) AUG 0 2	2006 32. Registrar's	Signature	1	and p				
Regist		AUG V &	LOUGH PARTIES	1.1 Jel	ORIGINÁL					

ian	1. Decedent's Name (First, Middle Probability Opening I			Cei	rincale	of Death	1:	2. Date of Death Month July 31. 2		Year	3. Time of Death 9:00 A M
cal ner	Richard Craig W 4a. Facility Name (If not institution 13 Arwell Court		ımber)			wn, or Location	of Death	July 31, 2	4c. Co	unty of Death Ltimore	
	5. Social Security Number 219 56 7306	6. Sex 1 ☐ M 2 ☐ F	7. Age (<i>In yr</i> s. 51	last birthday) Yrs.	If Under 1		-	3. Date of Birth (Month, Day,		9. Birth	place (State or Foreign ntry) more City, MD
Director	Usual Residence of Decedent 10a. State 10b. County Marry Land Baltimo 10e. Street and Number	ore		y, Town or Lo				10	or Citizon	of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ral Dir	13 Arwell Court	10 1/ 0	cedent Ever in U	S 42	2123	6	ining (Con-		USA	Race - Ameri	
by Funeral	11. Marital Status 1 ☐ Never Married 2 Marr 3 ☐ Widowed 4 ☐ Divorced	Armed F			was Deceder If Yes, specify	t of Hispanic Or Cuban, Mexica		ican, etc.)		Black, White,	
Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)) (1-4or 5+)	(Give	dent's Usual (kind of work DO NOT use Supervis	done during mos retired)	st of working	9		of Business/In	
To Be Co	17. Father's Name (First, Middle, Carl C Wilkins Sr			Lawr.	xpervis	18. Moth		(First, Middle, M M Piperat	faiden Sui		0
	19a. Informant's Name/Relations Kerry Wilkins	hip (Type, Print)						Route Number, Md. 2123		own, State, Zip	o Code)
	20a. Method of Disposition 11□ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 □Removal from	State	Place of Disponentery, crea	matory or other	of or place) C August	Da : 3 200			ion - City or To	
	21. Signature of Funeral Service	- 1	who	L	assahn E	Address of Facili Uneral Ho ir Road F	me Inc				
	23a. Pan1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	cabsed the deat each line. (or as a conseq	RE		of dying, such as			st,		Approximate Interval Between Onset and Death
Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	s	o (or as a consequence of or a consequence or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence or a consequence of or a consequence of or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a								
by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live	utcome of pregna birth 2 Feta prant at time of d nown	Ideath 3	Ectopic preg				23d	. Date of delive	eery Day Year
	Part tl, Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying cau	se given in Part	l.	23e. Did tob	. 1		the cause of death?
Completed								24a. Was ar autopsy perform 1 Yes 2	,	4b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
To Be	25. Was case referred to medica examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	Hospitat: 1 28a. Date	Inpatient 2 De of Injury	ER/Outpatier 28b. Time of tnjury		Othor	ursing Hom	e 5 Reside 8d. Describe ho	nce 6	Other (Special Courred	fy)
	3 ☐ Suicide 6 ☐ Could	not be 28e. Plac	e of Injury - At h	ome, farm, str y)	reet, factory, o	ffice	21	3f. Location (Str City or Town		umber or Rura	al Route Number,
	4 Homicide	ļ.									
edical Certification:	29a. Certifier 1 Certifyir		basis of examina nner stated.	ition and/or in	vestigation, ir	my opinion, de	ath occurred	d at the time, da	ite and pla	ice, and due t	to the cause(s)
Certification:	29a. Certifier (Check only 2 Medical	Examiner: On the land mai	basis of examina nner stated.	ition and/or in	vestigation, ir	my opinion, de	ath occurred	d at the time, da	ite and pla	ice, and due t	to the cause(s)

DHMH 17 Rev 1/2001

AUG 0 2 2006

Baltimore, Maryland 21215-0036 RICHARD WILKINS

Division of Vital Records, P.O. Box 68760,

06-05581 Jo

Please Type or Print in Black Indelible Ink

ohn Weiss, Jr.			ryland / Depa						jiene			
	_ [- For State legistrar	Cer	tificate of	Death		_	15	Date of De	Reg. No.	200	6 2423
Physicia ledical Examii	ner	1. Decedent's Name (First, Middle,Last) John William Wei							Month July 31, 2	Day 2006	Year	3. Time of Death 014 l hrs
		4a. Facility Name (if not institution, give street a Johns Hopkins Bayview Medical	Center		b. City, Tow Baltimo	re				Ва		e City
Funeral Director		5. Social Security Number 6. Sex 1. 34 8020 6. Sex	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Months	_	Hours	Min.	8. Date of B July 7		Forein	hplace (State or n untry) Mary Land
any	F	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	on							10d. Inside City Limits
Maryland 28a-f show 1 at once.	힕	Maryland Baltimore 10e. Street and Number	Balt	imore Cou	nty 10f. Zip Co	ode				10g. Citizen	of What Cour	1 Yes 2 No
with the Maryland ins 23a or 28a-f sho be notified at once	Dire	5 East Maple Avenue			2120					USA		,
ter death with ", or items 2 er must be n	Fune	1 Never Married 2 X Married 1 X Married 3 Widowed 4 Divorced If Yes, G	ve Year106/1_1065	If Ye	Decedent of Specify Constant of Specify Consta	Cuban, M	exican, Pı		cify Yes or N can, etc.)		Race - Ameri White, etc. c <i>ify:</i> Whit	can Indian, 8lack,
Baltimore, MD 21215-0036 pennit Tages I and 2 should be fited within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify only higher Elementary/Secondary (0-12) Coll	ege (1-4 or 5+)	16a. Decedent' during mo	s Usual Oc	cupation g life. D((Give kin				of Business/I	ndustry
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be Com	11 17. Father's Name (First, Middle, Last) John William Weiss Sr	N/A	Cammerci	al Cra	18.			irst, Middle,	Maiden Surr	<u>Employe</u> name)	XI
MD 212 nd 2 should b alth and Men m 27 is mar		19a. Informant's Name/Relationship (Type, Prin Anne M. Weiss (Wife)	t)	19b. Mailing						imber, City or aryland		Zıp Code)
Baltimore, M pernit Pages I and 2 Department of Health Important: If item 2 injury or other traur		20a. Method of Disposition	oval from State	Place of Disposition of Place of Disposition of Place of	tion (Name er place)	of cemete	ery,	1	Date	20c. Loca	nore, Mar	
Baltir pennit P Departme Importar	ı	2 gnature of Funeral Service Licensee	Sarang							Belair imore,M		4
Physician /Medical		23a. Part I. Enter the disease, or complications failure. List only one cause on each line.						diac or r	espiratory a	rrest, shock, o	or heart	Approximate Interval Between Onset and Death
Examiner			erosclerotic or as a consequence of		scular	dise	19:					2001
	iner	cause. Enter Underlying Cause	or as a consequence of	f):								
uled Id ransit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (in the death) Last	or as a consequence of	f):								
5, be executed sician and nurial - transit	edical	X UNPENDED AMEN	1tem#23a,		,g858,8	3/25/0)6 TT					
Records, P.O. Box 68760. The law requires that the death certificate becare has been signed by the attending physipage 2 should be detached for use as the fin		23b Was decedent pregnant in the past 12 months?	f yes, outcome of pregr Live birth Pregnant at time of de Unknown	2 Fet	al death er <i>(Specif</i> y		Ectopic pr	regnand	_{су}	23d Da Mor	ate of delivery	Day Year
P.O. Es that the can be gened by the contracted	by P	Part II. Other significant conditions contrib	iting to death but not re	esulting in the u	nderlying ca	ause give	n in Part I	I.	r			the cause of death?
Division of Vital Records, P.C rate of Acteuding Physician: The law requires that is after death at Director: After this certificate has been signed be led in by the funeral director, page 2 should be detailed in by the funeral director, page 2 should be detailed in by the funeral director.	Completed			············					perf	s an 2 opsy formed? 2 No		topsy findings available completion of cause of
Vital Rec ysician: The l nis certificate l	Be	25. Was case referred to medical examiner? Hospital:				104	Death (Cl		-			
n of Vit Jing Physic After this funeral dire	၉	1 Yes 2 No	Date of Injury	ER/Outpatient 28b. Time of Ir		c. Injury a			Home 5 8d. Describe	Residence how injury o		:
Sion (vitendin death etor: Al	cation	1 x Natural 5 Pending Investigation	(Month, Day, Year)	ana farm atro			2 N		Of Lastina	(Stand and)	lumbas as Di	and Davide Number City
Division of Vital I Hospital or Attending Physician: 44 hours after death Funeral Director: After this certifi lely filled in by the funeral director.	Certification:	Suicide 6 Could not be determined (S	e. Place of Injury - At ho	onie, iaim, stree	et, ractory, o	ince build	airig, etc.		or Town,		Number of Ru	ral Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Physician: To (Check only one) 2 Medical Examiner: On the										
F 3 F 3	Me	29b Signature and title of berthier	M			icense n				29d Date		nth, Day,Year)
		30. Name and address of person who complete Susan Hogan MD. Assistant	ed cause of death (Item Medical Examiner		n Street,	Baltim	ore, MI	212	01			
S Regis	tate trar	31. Date filed (Month, Day, Year) AUG 0 2 2006	32. Flegistrar's Signatu	L Ana	Me 3							
DHMH 17 Rev 1/2	2001		1-000	ORIGINAL	L							

			For State Registrar	State of Mary		partment of e <i>rtificate o</i>		nd Men		ene 0 0 1	6 24240
	2		Decedent's Name (First, Middle, La	st)					Date of Death		3. Time of Death
	/sicia ledic		John F. Ward						${\stackrel{\scriptscriptstyleMonth}{\mathrm{uly}}}27$.	,	8:15 P M
	amin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town	n, or Location of	Death		4c. County of [Death
	ä		Lorien Nursing			Bel Ai		A Hro		Harfor	
Fune Direc			5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthda 85 Yrs.	Months Day		Min. (Date of Birth Month, Day, Y Oril 5,	ea <i>r)</i> 1921 De	Birthplace (State or Foreign Country)
	tor	-	Usual Residence of Decedent		0,5			A	<u> </u>	1921 De	laware
nylani how	3		10a. State 10b. County	10	c. City, Town or	Location					10d. tnside City Limits
e Ma	Agua I	cto	MD Harford		Bel Ai	r					1 □ Yes 2 No
vith th	2	Director	10e. Street and Number			10f. Zip Code	9		100	, Citizen of Wha	t Country?
e 23e			217 Wakely Terra	CE 12. Was Decedent Ever	in II S I 1	2101 d 3. Was Decedent of		in? (Canady	Voc or No	USA	American Indian,
ter de ftsm		Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	m 0.5.	If Yes, specify C	uban, Mexican,	Puerto Rica	in, etc.)		White, etc.
urs at		þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2≧N	No Specify:	whit	.e	Specify:	white
72 ho	E	Completed	15. Decedent's E	ducation	16a. De	cedent's Usual Occive kind of work do	cupation	of working	16	ib. Kind of Busin	ess/Industry
dithin	Me	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life	i. DO NOT use ret	ired)	o			_
lled w tygier her ti	2		12 17. Father's Name (First, Middle, Last	1	Tim	ekeeper	10 Mother	r's Nama (Fi		Bechtel	Corp.
Lail y latifue (8 A	Be	William Ward	,					nningh	ŕ	
Shoute Thank	Fig. 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number										te, Zip Code)
and 2 Balth a m 27 ls	r tre		Dorothy Ward - W	21	7 Wakely	Terrace	e Bel	Air. M	21014		
of Hear	to the		20a. Method of Disposition 1 □ Burial 2 🛎 Cremation 3 □	2 2 2 2 2	0b. Place of Dis	position (Name of rematory or other p	olace)	Date	20	c. Location - Cit	y or Town, State
Pages ment of h	nry o		4 □ Donation 5 □ Other (Special		Metro	Crematory	τ Jι	u1v 30	. 06	Baltimor	e. MD
Deficiency with yield A 12.13.0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itsme 23a or 28e-5 show	eny In		21. Signature of Funeral Service Lice	ee /	ty of	Maryla	nd, Inc. e, MD 21				
405	* 0		MINE X	chlang	in	299 Frede	erick Ro	oad Ba	ltimore	e, MD 21	
			23a. Part . Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final					cardiac or res	spiratory arres	i,	Approximate Interval Between Onset and Death
Physic /Medi			disease or condition resulting in death)	a CEREBROV		AR ACGO	ENT				
Exami				Due to (or as a co	nsequence of):						
	*	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	nsequence of):						
of po	ransii	Examine	that initiated events	C							
96 exe	-ial-	EX	resulting in death) Last	Due to (or as a co	nsequence of):						
Attending Physicien: The law requires that the death certificate be executed er death.	the b	dicai	•	d							
certifi	Se as	Physician/Me	IF FEMALE:	23c. If yes, outcome of pr	regnancy					23d. Date of	deliver
Jeath s atter	1 Join	Iclar	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐ 4☐Pregnant at time		3 □Ectopic pregnat 5 □ Other (specify)				Month	Day Year
t the	асре	hys	9 Unknown	9□ Unknown							
s tha	90 de		Part II. Other significant conditions	-	•	, ,	given in Part I.		23e. Did toba	cco use contribu	te to the cause of death?
require	pino	ted	DYSPHAGIA CO	PRONARY AR	TERY DI	SEASE,			1 🗋 Yes	2 No 3	Probably 4 Unknown
law r	9 2 Sh	Completed by	CHRONIC OBSTRUC	TIVE LUNG	DISEASE				24a. Was an autopsy	24b. Were	e autopsy findings available to completion of cause of
The	pag	Con							performe 1□ Yes 20	d2 deat No 1□	
VII.C	rector	Be	25. Was case referred to medical examiner?	Hospitat:		1			neck only one)		
Phys 2	<u>a</u>	2	1 Yes 2 No 27. Manner of Death	1 LI Inpatient	2 ER/Outpat	ION JUDOA	4 PE NUI:	1		e 6 Other (Specify)
th. Afte	tune	Certification:	1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Yean	a <i>r)</i> Injur		njuryat Vork? □Yes 2 □ N	j		,,	
Atter dea	by th	ifice	3 Suicide 6 Could not b		At home, farm,	street, factory, office	08	281.	Location (Stree	et and Number o	r Rural Route Number,
s after 5	U 00	Cert		building, etc. (5	p o city)				ony or rown,	state)	
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and A	completely filled in	Medical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example	nysician: To the best of my niner: On the basis of exa	y knowledge, de mination and/or	eath occurred at the investigation, in m	time, date and y opinion, death	d place, and o	due to the caus	se(s) and manne and place, and	r as stated. due to the cause(s)
thin 2	ejdwo	Med	29b. Signature and title of certifier	and manner stated.		29c. Lice	ense number		29d	. Date signed (M	Ionth, Day, Year)
F 3 F	5		> Will	enter M	λ	N.	457111	ſ		128/20	
1 L	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						45344		ŧ		00
10			SURESH DHANJA	N/ MD 622 5	SIVATOR	Print) AVE, HA	WRE DE	GRACE	E MO :	21078	
	Sta		31. Date filed (Month, Day, Year)	32. Papistrar's	Signature	1-1-		,	(
Re	gistr	alf	AUG 0 2 2	UUb Mosure	D. 1	gover.		· · · -		-	

		1 - For State Registrer	State of Ma	•	epartment of Certificate of			jiene •g. No.2 0 0 6	24241
		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	th	3. Time of Death
Physici		EDWINA 1	YATT				Month	Day Year	1 . 3 . 11
/Medio Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of Death		4c. County of Dea	
		JOHNO HOOKEN & BA	YUTEN (MR	ELENTE	R BAUTI	more m	D		
Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birt	hday) If Under 1 Year	r If Under 24 Hrs.	8. Date of Birth	9. Bi	rthplace (State or Foreign country)
Director		Usual Residence of Decedent	□ M 2(X)F	79	rs. Months Days	Hours Min.	8. Date of Birth (Month, Day Feb. 7	, 1927	N C
irylar thow	_	10a. State 10b. County		10c. City, Town					10d. Inside City Limits
Ba-f.s	cto	MD Baltimo	ore	Dund	aık 				1 ☐ Yes 2 🛣 No
death with the Maryland ma 23a or 28a-f show	Funeral Director	10e. Street and Number 2023 Jasmine Ro	ad		10f. Zip Code 2 1 2 2 2	2	1	0g. Citizen of What C	ountry?
	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of	Hispanic Origin? (Spe ban, Mexican, Puerto	cify Yes or No-	14. Race - Am	
or Ity		1 Never Married 2 Married	1 ☐ Yes 2 ☐X	lo	1 Yes 2 XNo		riican, etc.)	Black, Wh	
es la la la la la la la la la la la la la	d by	3 ☐ Widowed 4 ▼ Divorced	Year or Dates:		TEL 195 ZENIAC	зресну.		Specify: W	nice
"nai	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	ipation e during most of working ed)	ng	16b. Kind of Business	s/industry
a filed within 72 hours af I Hygiene. othar than "natural", or rant, the Medical Exam	E O	11	Johnsys (1 401 5	,	Baker's	Assistan	t	Herman's	Bakery
nd 2 should be file Ith and Mental Hy, 27 Is marked oths traumatic evant,	0	17. Father's Name (First, Middle, Last,)			18. Mother's Name			
Mental Mental rked o	To B	Quincy T. Wyat	t			Bertha	M. Rob	erts	
2 should be and Mental Is marked aumatic ev		19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Stree	t and Number or Rura	l Route Number	City or Town, State,	Zip Code)
nd 2 salth ar		Kenneth Sorrell	l - Son		609 S. Jo				
Pages 1 an nent of Heal int: If Item 2 iry or other		20a. Method of Disposition		20b. Place of	Disposition (Name of crematory or other pla	D	ate	20c. Location - City or	Town, State
age ent o it: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif	Removal from State		ew Crematory or otner piz	l l	-06	Baltimo	ro MD
artme ortan injur		21. Signature of/Funeral Service Licer		раучт			The second second		neral Home
permit. Pages 1 and 2 Department of Health inportant: if I tem 271 any injury or other tra		> Fishalut	\rightarrow		PA, 2134	Willow	Spring	Road, 2	
Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. PNEUM	the death. Do ne.	×	ing, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
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v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 9 Unknown	2 🗌 Fetel death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	ey .		23d. Date of de Month	livery Day Year
uires that signed t	d by PI	Part II. Other significant conditions of PLEURAL EFFUST			the underlying cause gr			acco use contribute to	the cause of death?
w requir been si should	ete	2 -2 -2					04-146		
> 0 0			VLATLOW				24a. Was ar autops perform	prior to	utopsy findings available completion of cause of
ne taw has b je 2 sl	mp								2 X No
: The law cate has b ; page 2 sl	Completed by		HEIVE				1 □ Yes 2	1 1 103	
ician: The ław sertificate has b ector, page 2 sł	Be		HRIVE		0.0	26. Place of Death	Check on one	9	5
rhysician: The ław this certificate has b al director, page 2 sl	To Be	PAILURE OF THE 25. Was case referred to medical examiner? 1 Yes 2 XNo	Hospital: 1 Inpatier	nt 2□ER/Out	Dallett J DOA	her: 4 Nursing Hon	Check on one		5
ng Physician: The law der this certificate has b uneral director, page 2 sl	To Be	PATOLIC TO THE 25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Manner of Death	HOSDITAT:		me of 28c. Inju	her: 4 Nursing Hon	Check on one	a	5
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Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) Date of Death Physician/ Month Day July 27, 2006 Medical Examiner 2304 hrs Ma 4a. Facility Name (if not institution, give street and number) 4c County of Death University Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months Days Director 1984 1 M Usual Residence of Decedent 10c. City, Town or Location any 10d Inside City Limits s 23a or 28a-f show a e notified at once. Yes 2 WNo hours after death with the Maryland Director 10e. Street_and Number Apt.C 10g. Citizen of What Country? Funeral 11 Martral Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 8lack or items Never Married Armed Forces? White, etc. Yes 2 No 3 Widowed 4 Divorced If Yes. Give Year Yes 2 No specify. "natural", è 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr Completed during most of working life. DO NOT use retired) College (1-4 or 5+) item 27 is marked other than traumatic event, the Medical Baltimore, MD 21215-0036 ges 1 and 2 should be filed within t of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mothe 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Important: If it injury or other t crematory or other place) 2 Cremation 3 Removal from State 3 -06 ausdrine Donation 5 Other Spec 22. Name and Address of Facility ignature of Funeral Service L Back, m. wallace Weldel Md,21229 the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and /Medical a. Multiple Injuries with complications Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical ysician a burial -UNPENDED AMENDED Box 68760, IF FEMALE: phy the b 23c. If ves. outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ੬ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed? death? 1 🗸 Yes After this certificate ✓ Yes 2 25. Was case referred to medical 26 Place of Death (Check only one) To the Hospital or Attending Physician: Be Hospital: 1 / Inpatient 2 Other₄ DOA ER/Outpatient 3 Nursing Home 5 Residence 6 1 🗸 Yes 28a. Date of Injury (Month, Day Year) May 6, 2006 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Passenger auto auto collision Natural 1645 hrs Yes 2 V No 5 Pending the Funeral Director: hours after death 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 1-295 at I-895, Brooklyn, MD determined (Specify) Interstate/Express Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Lo and manner stated 29b Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E July 29, 2006 30. Name and ad ress of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State AUG 0 2 2006 Registrar

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			1 - For State Registrar	State	of Maryland	d / Depa <i>Cer</i>	rtment of Hetificate of E	ealth an Death		jiene	06	24243
	Dt		1. Decedent's Name (First, Middle	e, Last)					2. Date of Dea Month ,	Day	Year	3. Time of Death
	Physicia /Medic		Ruth Erna	stine A	Amiraul	t			July	25	200C	1137Am
	Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, or	Location of D	eath	4c. County		
	2		437 Bernice				Aberde				ford	
L	Funeral Director		5. Social Security Number 213-66-6830	6. Sex 1 ☐ M 2 AF	7. Age (In yrs. Ia		Months Days	Hours N	Ain. 8. Date of Birth (Month, Day 02/01/1	927	9. Birthp Coun Germ	lace (State or Foreign try) any
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Loc	ation				1	0d. Inside City Limits
	danyl f sho	ŏ	MD 116-			Above	Joon					1 XYes 2 □ No
	the 28a-	Director	MD Harfo	ora		Abero	10f. Zip Code		1	Og. Citizen of \	What Coun	itry?
	3e or		437 Bernice 5	Porrace			2100) 1			S.A.	,
	death ms 2	Funerai	11. Marital Status	12. Was Dec	edent Ever in U.S	3. 13. V			? (Specify Yes or No- uerto Rican, etc.)	14. Rac	e - Americ	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or itams 23e or 28a-f show eny injury or other traumatic avant, I'm Medical Exam not until be indiffed at once.	by Fur	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Vac G	2 ŽNo ive	I	Yes, specify Cubar ☐ Yes 2 No		uerto Rican, etc.)	Specify	ok, White, V: Wh	etc. ite
ò	2 hou	ted	15. Deceden	t's Education		16a. Deced	ent's Usual Occupa	tion		16b. Kind of B		
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yla	Duld by Ment arked arked	၉	Richard A.	Scholz				Emma	Wolffe			
lar	2 should be and Mental Is marked craumatic ave		19a. Informant's Name/Relations			11			r Rural Route Number			_ ′
	l and lealth im 27 ther t		Paul Amiraul 20a. Method of Disposition	t (son)	20h Pl	_	odmar C	t., K	ingsville Date		2108	
וסנ	if its		1 XBurial 2 ☐ Cremation		State ce	metery, crem	atory or other place	· I		20c. Location -		
Baltimore,	it. Partmer rtant rtant njury		4 □Donation 5 □ Other (S21. Signature of Funeral Service		Bake	er Cem			/28/2006		en, M	J
Ba	Depar Depar Impo eny ir		21. Signature di Entingal Service	J. Z	0_11	T:	arring—Ca 33 South	rgo Fu Parke	neral Home St., Aberd	P.A. leen, M	210	01
П	₹.		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the death. each line.	Do not ente	r the mode of dying	, such as care	diac or respiratory arm	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a.	Von Sin	all Ce	Il Lang	Carci	noma			Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consequ	ence of):	J		-			
н		_	Sequentially list conditions,	b. — Does in	(of as a consequ	HITCH OUT						
\mathcal{J}	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	((or as a comoqu	31100 017.						
,	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consequ	ence of):						
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9	g phy as th	edi								1		
.O. Box	The law requires that the death certification is the has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	atcome of pregnant birth 2 Fetal mant at time of de- nown	death 3	Ectopic pregnancy Other (specify)			23d. Dat Mo	e of delive	ry Day Year
ري	res tha	by P	Part II. Other significant condition	ons contributing to	death but not resul	ting in the un	derlying cause give	n in Part I.	23e. Did tol	acco use conti	ribute to th	e cause of death?
ıd	w require been sig should b	pa							1 □ Ye	s 2□No	3 Prob	ably 4 Onknown
Records,	e law requ has been je 2 shoul	Completed				_			24a. Was a autops perforr		Vere autoporior to con	osy findings available appletion of cause of
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Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Otho		Death (Check only on			
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on	th. : Afte	tior	1 Natural 5 Pendin 2 Accident investig	9	nth, Day Year)	Injury	Work'			, , ,		
Division of	Attanding ir death. actor: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could of	not be 28e. Plac	e of Injury - At hor	ne, farm, stre	et, factory, office		28f. Location (St	reet and Numb	er or Aurai	Route Number,
á	s afte	Certification:	4 Homicide	build	ling, etc. (Specify)				City or Town	, State)		
	To tha Hospital or Attanding Phwithin 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 1 Certifyin 2 Medical	Examiner : On the l	e best of my know pasis of examination oner stated.	rledge, death on and/or inv	occurred at the time estigation, in my opi	e, date and plant nion, death o	ace, and due to the ca ccurred at the time, da	ause(s) and ma ate and place, a	nner as sta and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of cont ie	1	_		29c. License	number		9d. Date signed		
			- David	turn o	7		itoc"	544139	•	Julys	26,2	300
	13		30. Name and address of person	who completed cau	se of death (Item ムドルロ	23a) (Type, F	rint)	Bei A		1015		
	Sta	te	31. Date filed (Month, Day, Year)		gistrar's Signatu) mr. a					
	Registr	ar	AUG 0 2	2 2006	G. 2000 A	1 /	and					

		1	For State Registrar	State of Marylan		artment			ind Me		giene Reg. No.	2006	24	244
T	Dhysiais		1. Decedent's Name (First, Middle, Last)	2 2						. Date of De	ath	2006 Year	3. Time of	
	Physicia /Medic	al -	Rebecca Abrams 4a. Fecility Name (If not institution, give s			4b City	Town, or	Location o		иту л		County of Death	2:07	₽ М
	Examin	er	The Hebrew Hom			Rock					Moi	ntgome	rv	
	Funeral	1	5. Social Security Number 6. Sex	7. Age (In yrs.					Min. 8	. Date of Bir (Month, Da	th y, Year)	9. Birth	place (State ontry)	or Foreign
	Director	-	080-12-7637 Usual Residence of Decedent	M 204F 85	Yrs.				Ac	ril 22	2, 1921	New_	York	
	yland now		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation							10d. Inside C	•
	e Mar Ba-f sl	Director	DC	Was	shingt	1					10- 0%			2 No
	with the	D Le	10e. Street and Number	L NITAT		10f. Zip					U.S.	zen of What Cou	intry :	
	death	Funeral	3242 38th Stree	12. Was Decedent Ever in U Armed Forces?	I.S. 13.			ispanic Orig	gin? (Specif	fy Yes or No		• A • 14. Race - Amer Black, White		
98	or Ite	y Fui	1 Never Married 2 Married	1 ∐ Yes 2 X No If Yes, Give		1 ☐ Yes		Specify:	, , , , , , , , , , , , , , , , , , , ,	Jan, 510.7			hite	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23e or 28a-f show he Mardical Exerciner must be notified at	ed by	3 ☐ Widowed 4 ☒Divorced 15. Decedent's Educ	Year or Dates:	16a. Dece	dent's Usua	il Occupa	ation			16b. Kir	nd of Business/l	ndustry	
215	thin 72 9. Ban "ng	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of wor DO NOT us	nk done d se retired	during most !)	of working					
2	led wil tygien her th nt, the		17. Father's Name (First, Middle, Last)	4	Sales	pers	on	18 Mothe	r's Name (i	First, Middle	Ret			
and	d be fi	o Be	Jacob Abrams							Putzh				
aryl	shoul	၉	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Maili	ng Address	(Street a	and Numbe	or Or Rural F	Route Numb	er, City or	Town, State, Z	ip Code)	
ž	and 2 ealth a n 27 ls		Sylvia Abrams (Sis					eet, I	N.W.,V			DC 200		
ore	iges 1 at of H if iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		Place of Dispo cemetery, cre :10nal	matory or o	ther plac	(a)				s Church		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examination at any injury or other traumatic event, the Medical Examination at any injury.		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Par	rk –							neral 1		
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			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the dea ne cause on each line.	th. Do not en	ter the mod	e of dyin	g, such as	cardiac or r	espiratory a	rrest,		Approxima Interval Be Onset and	tween
1	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Adenoca		oma o	f L	eft :	Breas	st				
	Examiner		f f	Due to (or as a consec	quence or):									
	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):									
	xecute and II-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):									
760,	ate be executed hysiclan and he burial-transit	calE		1										
89	eath certificat attending phy I for use as th		IF FEMALE:						- 11 Lange			1	200	
Вох	ath ce attendi for use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1□Live birth 2□Fet 4□Pregnant at time of	al death 3	□Ectopic pr					2	23d. Date of deli Month		Year
o.	at the de by the a tached	hysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9☐ Unknown										
ds, P	ss tha	by	Part II. Other significant conditions con Schizophreni		sulting in the I	underlying o	ause giv	en in Part I			tobacco u Yes 2≹	se contribute to SNo 3 □ Pro	the cause of obably 4	
Vital Records,	aw require ts been sig 2 should b	Completed								24a. Was		24b. Were au	topsy findings	available cause of
Ä	The lav	Com									ormed? 2⊠ No	death? 1 ☐ Yes	2□ No	
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:	75000		Oth		(= /// - // · ·	Check on		5 □Other (Spec	2(6.1)	
of	를 끌 등	n; To	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time		28c. Injur Wor	4 (2)40	-	d. Describe			л(у)	
ion	ttending I death. ctor: After y the funer	atlo	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(WORLI, Day 1881)	Injury	М		Yes 2□						
Division	or Atterder de Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, s ify)	treet, factor	y, office		28		(Street and own, State	d Number or Ru)	ral Route Nur	nber,
	To the Hospitel or Attentwith 24 hours after deatl To the Funerel Director: completely filled in by the	edical Ce	29a. Certifier 1X Certifying Phy (Check only one)	sicien: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, dea	th occurred	at the tir	me, date an pinion, dea	nd place, an	d due to the	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
	Fo the vithin 1 or the comple	Med	29b. Signature and title of certifier	(290	c. Licens	e number			29d. Dat	e signed (Month	n, Dey, Year)	
			1 Hornes	anin	w		00	0 18	808	4	Ju	4 12	, 200	6
2	(5)		30. Name and address of person who co					2015/2	201.70					
		ate	Dinesh Patel, M 31. Date filed (Month, Day, Year)	.D. 6121 Mc	nature			KOCK	<u> </u>	e, ML	208	352		
	Regist		.111 1 9 2006		K do	we								

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760, ospitel or Attending Physician: The law requires that the death certificate be executed

Baltimore, Maryland 21215-0036

Certification; To after death. 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by within 24 hours a Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) ÷ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0061106 30. Name and address of person who compeled cause of death (Item 23a) (Type, Print)

Pradeep Srivastava, M. D. 7227 Justi Jagtap, M.D 7227 B Hanover Parkway; Greenbelt, Md. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUL 1 9 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () [] [Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July 15, ^{Day} 2006 Year **Physician** Alma L. Avitia 2:15 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 9349 Worrell Avenue Lanham Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, NOV 26, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2X F Yrs. Mexico 461-50-8966 69 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 **X**Yes 2 □ No Directo Prince George's Lanham Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9349 Worrell Avenue 20706 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ≥ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 XYes 2 ☐ No Specify: Specify: White þ Mexican 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Nurse Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Juan Kelly Catalina Romero Alcalde 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Serafin Avitia (Husband) 9349 Worrell Avenue, Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 7/19/2006 Clinton, MD 21. Signature Fu eral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham, MD 20706 M. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) immediate Due to (or as a consequence of): 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other treumatic event <u>once.</u>

Funeral

Director

?7 is marked other then "naturel", or Items 23a or 286-1 show treumatic event, the Medical Exact precriment be notified at

be filed within 72 hours after di Ital Hygiene. Id other then "naturel", or Item

Baltimore, Maryland 21215-0036

with the Maryland

death

ed by the attending physician and detached for use as the burial-transit

The law requires that the death certificate be executed After this certificate has To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica

Division of Vital Records, P.O. Box 68760,

State Registrar 29b. Signature and title of certifier

29c. License number D0040904

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

28d. Describe how injury occurred

1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one.

Marda Lane, Anna polis, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

1 🗌 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

31. Date filed (Month, Day, Year)

JUL 1 8 2006

5 Pending investigation

6 ☐ Could not be

25. Was case referred to medical

1 ☐ Yes 2X No

27. Manner of Death

1 Natural 2 Accident

3 🗍 Suicide

29a. Certifier

4 Homicide

2 ER/Outpatient

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

3□ DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			1 - For State Registrar	State of Mar	-	partment of He ertificate of D			ne . No. 2006	24248
			Decedent's Name (First, Middle, L	ast)				2, Date of Death Month		3. Time of Death
	Physici /Medic				chinsor	1		July	16,2006	4:55P [™]
}	Examir	er	4a. Facility Name (If not institution, grant Southern Mary		i + o 1	4b. City, Town, or L			4c. County of Deat	
_	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. last birthd	ay) If Under 1 Year		8. Date of Birth	Prince 9. Birt	hplace (State or Braign untry)
	Director		579-34-8355	1 M 247 F	80 Yrs	Months Days	Hours Sep	8. Date of Birth (Month, Day, You Lember 1	$[0, 1925]^{\circ}$	Washington
	and w		Usual Residence of Decedent 10a. State 10b. County		IOc. City, Town o	Location				10d. Inside City Limits
	Maryl	tor	MD Charl		India					1 ☐ Yes 2 XNo
	or 28a	lrec	10e. Street and Number		Indiai	10f. Zip Code		10g	. Citizen of What Co	untry?
	ath wil	ralD	31 Elder Plac			2064	0		USA	
	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23a or 28e-f show ther than madical Exans are must be undified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No		 Was Decedent of Hisp If Yes, specify Cuban, 	panic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
5-0036	urs aff	þ	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White
S C	72 ho	Completed	15. Decedent's E (Specify only highest g		16a. De	cedent's Usual Occupati	on ring most of works	na 16i	b. Kind of Business/	Industry
121	within ane. than	du	Elementary/Secondary (0-12)	College (1-4or 5+)	lif	a. DO NOT use retired) Homema	kor		Hom	0
N O		0	17. Father's Name (First, Middle, Las	it)				(First, Middle, Ma.		е
<u>lan</u>	Aental Aental rked c	To B	Frank Biggs				Vesta	a Hancoc	k	
Maryland	2 sho and N le ma		19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Address (Street an	d Number or Rura	l Route Number, C	ity or Town, State, Z	Tip Code)
_	1 and teelth em 27 ther tr		Joyce Johnson/ 20a. Method of Disposition			South Pla		7 10	h NY 12.	
ğ	ages ant of h t: If h		1 Neurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Damoual from State	cemetery, o	rematory or other place) by Baptist	_	200	•	
Baitimore,	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If Item 27 Ie marked eny injury or other traumatic es		21. Signature of Funeral Service Lice		M00945	22. Name and Address		20,00	arry emoy	, mary rama
ă	Depa Depa Impo eny ir		Bavel.	Echol)		AREHART-E	CHOLS I	FUNERAL	HOME, P.	A.
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the y one cause on each line.	e death. Do not	enter the mode of dying,	such as cardiac 6	respiratory arrest	PLAIA,M	Approximate O Interval Between Onset and Death
	Pnysician /Medical		tmmediate Cause (Finat disease or condition resulting in death)	a	Memia				Í	Onset and Death
	Examiner			Due to (or as & o	consequence of):					
	P F	Der	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	b. — Due to (or as a c	onsequence of).					-
	and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
8/60,	icate be executed physicien and s the burial-transit	al E		Due to (or as a c	consequence or).					
200	uficate g physas the	edical		_ d		-				
ŏ	th certendin	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐Live birth 2		3 □Ectopic pregnancy			23d. Date of deli	/
	the at	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at tin 9□Unknown		5 Other (specify)			Month	Day Year
ŗ	law requires that the death certific es been signed by the attending p 2 should be detached for use as		Part II. Other significant conditions	contributing to death but	not resulting in the	e underlying cause given	in Part I.	23e. Did tobac	co use contribute to	the cause of death?
cords,	quires an sigr uld be	ed by	Expoliative Des	mants				1 ☐ Yes	20 No 3 □ Pro	obably 4 Unknown
ဝင္	lawre es bee 2 sho	Completed						24a. Was an autopsy	24b. Were au	topsy findings availabte ompletion of cause of
<u> </u>	: The law cete hes , page 2 s	Co						performed 1 ☐ Yes 2 ☑	death?	2110
VITA	Physicisn: Th this certificete ral director, paç	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	• C 50/0 ·	Othor		(Check only one)		
0	g Phy er this eral d	n: To	27. Manner of Death	1 Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpa	of 28c. Injury a	4 🗆 Nursing Hor	ne 5 Hesidence 28d. Describe how i	e 6 □Other (Speciniury occurred	afy)
SIO	Attending or death. ector: After by the fune	atlo	1 Natural 5 Pending 2 Accident investigation	on	'ea <i>r)</i> Infur		s 2 No			
DIVISION	To the Hospital or Attending Physicism: Within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director,	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, (Specify)	street, factory, office	2	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
_	spital		29a. Certifier 1 Certifying P	hysician: To the best of r	my knowledge, de	eath occurred at the time,	date and place, a	and due to the caus	e(s) and manner as	stated
	the Ho in 24 l the Fu pletely	edical	one) 2 Nedical Exa	and manner states	kamination and/oi	investigation, in my opin	tion, death occurre	ed at the time, date	and place, and due	to the cause(s)
	With Con	Σ	29b. Signature and Albert of dertifier	4. 2		29c. License n	number	29d.	Date signed (Month	
530			30 Name and address of names with	completed cause of day	th (Itom 22a) /T	D U U S (5120	1 3	my 17	2006
1	186		29b. Signature and Althor deritier 30. Name and address of person who Richard Fahren 31. Date filed (Month, Day, Year)	328 Southern	Wewe.	SE Suite 311	O Washing	Wande Z	-0037	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Sparte 3		1	- Care	
	Registr	ar	JUL I S	J ZUUP	ر سرر س	0				

			1 - For State Registrar	State of Marylan	•	artment of F		•	giene Reg. No. 20	16	24249
П	Physici	an	Decedent's Name (First, Middle, Last) Charles August	us Bobo				2. Date of De	Day	rear .	3. Time of Death
	/Media	al	4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of De	July	4c. County of	Death	8:15A M
	Examin	er	11923 Amherst	Ave NE		Cumber		3401	Allec		
	Funeral Director		5. Social Security Number 6. Sex 218-16-3885	M 2□F 7. Age (In yrs. I		If Under 1 Year Months Days		lin. (Month, Da	th y, Year) 12,1925	Country	ce (State or Foreign West ginia
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				10d	1. Inside City Limits
	e Mar	ctor	Maryland Alleg	any Cu	mberl	and					1 □Yes 2 No
	th with th	Funeral Director	10e. Street and Number 11923 Amherst Av	ve NE		10f. Zip Code 2150	2		10g. Citizen of Wh	at Country	n
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importants if Item 27 is marked other then "natural", or Items 23a or 28a-f show spiringry or other traumatic event, Ira Madical Examinat be motified at ODGS.	þ	11. Maritaf Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW	1	f Yes, specify Cuba	ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or No- terto Rican, etc.)		American White, etc Wh	
21215-0036	within 72 ho ane. then "natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) Colfege (1-4or 5+)	(Give life. I	dent's Usual Occup kind of work done o DO NOT use retired	during most of (1)	working	16b. Kind of Busi		stry
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Maryland	2 sho and h is me		19a. Informant's Name/Relationship (Typ					Rural Route Numbe			
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Baltimore,	Pages nent of I int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	SITIOVAL II OILI OLALO		sition (Name of natory or other place	1				
alti	partme		21. Signature of Funeral Service License	9 0 —	nset ?	Mem Par Name and Addres	لالله K ss of Facility	y 31,20 Service	06 Cumb	erla	nd,MD
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	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):	heter	ictin	e Pulm	umary D	Sease	,
		Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):				J		
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.O. Box (The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetaf 4 □ Pregnant at time of de 9 □ Unknown	death 3□	Ectopic pregnancy Other (specify)			23d. Date of Month		ay Year
<u>α</u>	igned by be detac		Part If. Other significant conditions cont	Inbuting to death but not resu	Iting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contrib	ute to the o	cause of death?
rds	quires n sign uld be	d by									ly 4 □Unknown
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		Com						autop perfor 1 ☐ Yes	rmed? 🔔 dea	ath?	No Cause of
Vital	ician	Be	25. Was case referred to medical examiner?	ospital:		Othe		Death Check only or	ne)		
Division of	0 = 0	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun	4 LI Nursing	Home 5 Resid	lence 6 Other		
Sior	Attending F death. ctor: After y the funer	atlo	12 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Morni, Day 1 dar)	пцигу		Yes 2 □No				
DIV	2555	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Pface of Injury - At hor building, etc. (Specify,				City or Tow			
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier (Check only one) 12 Certifying Physical Examination	ician: To the best of my know er: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the time restigation, in my op	ne, date and pla pinion, death oc	ice, and due to the c curred at the time, o	cause(s) and mann date and place, and	er as state d due to the	id. e cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	H. Chotan	d'	29c. License			29d. Date signed (Month, Day	y, Year)
•			P	11 000			385	3	7/28	5/0	56
	6		30. Name and address of person who con	impleted cause of death (Item			10° C	Juenu (- _ \.	1.	NO DIESO
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure		MINO C	work !	Comon	and 1	MADIX
gâ.	Registr	ar	AUG 0 2 20	06 Males	K 4	certi					

		1	For Amend #1 Per State Registrar	State of Marylar Phy G858 8/				and Me	ental Hyg	jiene leg. No	_	_	24250
Phys	ician		Decedent's Name (First, Middle, Last)	C'11 D1	. 1	000	40		2. Date of Dea Month	Da		ır,	. Time of Death
	dica			Armfield Bond	- 3	12.01	4 19		JULY	13			il: II AM
Exa	niner		a. Facility Name (If not institution, give s				y, Town, or Location		TU	4c.	County of D	eath	
	de .		THE JOHNS HOFK i. Social Security Number 6. Sex				er 1 Year If Under)	9.1	Birtholace	(State or Foreign
Funei Diréct	_			M 2√F 46	Yrs.	Month		Min.	B. Date of Birth (Month, Day APRIL 8			Country)	IGTON DC
U		-	Jsual Residence of Decedent			1			TIVILL (, 12	OU WE	OILL	TGTON DU
within 72 hours after death with the Maryland then. than "natural", or iteme 23a or 28a-f ehow he Madical Examiner must be notified a			10a. State 10b. County		ity, Town or Lo	ocation						10d.	Inside City Limits TY Yes 2 No
s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygleno. Item 27 is marked other than "natural", or iteme 23a or 28a-1 ehov other traumatic event. Ite Medical Examinar must be notified.	Director		MD PRINCE GE	ORGE'S I	BOWIE								
MITT .	ä		Oe. Street and Number				Zip Code				zen of What	Country	?
10 23	Funeral	5	14904 NIGHT HAWK	LANE 12. Was Decedent Ever in U	J.S. 13		0716	igin? (Speci	rfv Yes or No-	U.	S.A. 14. Race - A	merican	Indian
Hen	9	5	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	,	If Yes, s	edent of Hispanic Or becify Cuban, Mexical	n, Puerto Ri	ican, etc.)		Black, W		maidi,
al', or	2		3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 No Specify:	•			Specify:	BLAG	CK
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Mental Hygiene. arked other that atic event, the		5		4 YRS	INSU	RANC	E SALES				VATE		
d oth	a a	3	17. Father's Name (First, Middle, Last)	TI D					First, Middle,		Sumame)		
Mer Parke	F		JOHN DAVID ARMFI						P. LEW				
h and 7 Is m traum		i	19a. Informant's Name/Relationship (Ty) ROBERT BOND/HUSBAN			-	ss <i>(Street and Numb</i> วบราย มหา <i>ส</i> ราช ร			-			
Health tem 27		-	20a. Method of Disposition		Place of Dispo		GHT HAWK I	Da Da			LAND cation - City	207	
Important: If Item Into njury or othe		1	1 🖾 Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, crei	matory o	other place)				ŕ		
Department of Important: If Is any njury or o			4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		INCOLN		ETERY and Address of Facili	7/21/2			rland,		
Dep							LANDOVER F		B. JE				номе 0785
		+	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dea							AN I LAN.	Ap	proximate
ysicia Medic			shock, or heart failure. List on or Immediate Cause (Final disease or condition resulting in death)	SEPS	15		, ,					Int	erval Between set and Death DAY 5
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attending physician and for use as the burial-transit	Physician/Med	T	F FEMALE:										
ttendi	Jue/		23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1□Live birth 2□Fet	aldeath 3[pregnancy				23d. Date of o	,	Von
the at	0		1 ☐ Yes 2 💢 No 9 ☐ Unknown	4☐ Pregnant at time of of 9☐ Unknown	death 5	Other	specify)				MOHIT	Day	y Year
signed by the signed be detached	P.	-	Part II. Other significant conditions con	tributing to dooth but not re-	nulting in the u	mala abaina	and the Part I		220 Did to	1	an anatributa		ause of death?
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been si	Completed	-							ļ			<u>_</u>	
has le 2	du								24a. Was a autops perfor	V	24b. Were prior t	o comple	findings available stion of cause of
certificate ha									Yes	2□ No	1 🗆 Y		K No
	8		25. Was case referred to medical examiner?	ospital:			Other		Check only or			-	
this al d	P	1	1 ☐ Yes 2 No ☐ 27. Manger of Dath	28a. Date of Injury	ER/Outpatier 28b. Time o		28c. Injury at		d. Describe h			pecify)	·
Afte fune	5		1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐			,	,		
ctor:	Certification:		3 Suicide 6 Could not be	28e. Place of Injury - At h	iome, farm, str		l		f. Location (S	reet an	d Number or	Rural Ro	oute Number,
Dire d in b	T d		4 Homicide	building, etc. (Speci	fy)		•		City or Tow	n, State)		,
within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical		29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of my knier: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurre	ed at the time, date an on, in my opinion, dea	nd place, an ath occurred	d due to the c I at the time, d	ause(s) ate and	and manner place, and d	as stated ue to the	d. cause(s)
withir To th	Z		29b. Signature and title of certifier	0		2	9c. License number		ł .		e signed (Mo		
18	-		1 mily 3	5			RES	000	•	JUL	4 12	- 2	006
<u>リ</u>	1		30. Name and address of person who co TIMOTHY BURNS, UPINS	mpleted cause of death (Ite	m 23a) (Type,	Print)	NOLFE STREET	BALTIN	more, MA	RYLA	mb, 2	1287	
200	State		31. Date filed (Month, Day, Year)	32. Registrar's Sign					·				
	istrar		JUL 1 9 2006 BL	en X do	ante								

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

			For State Registrar	State of	Maryland / Dep	ertificate of			giene Reg. No2 () () ()	24252
	A M &		Decedent's Name (First, Middle,	Last)				2. Date of Da Month	ath Day Year	3. Time of Death
	Physici /Medic		Andrew Blount					July	13 2006	3:11 P M
	Examin		4a. Facility Name (If not institution, g			4b. City, Town, o	or Location of Dea	ath	4c. County of Dea	
		1.0	Prince Georg				Chever			George's
	, Funeral		,	. Sex 7 1 🛣 M 2 🗆 F	'. Age (In yrs. last birthda)	Months Days	Hours Mir	s. 8. Date of Birn (Month, Da	v Year) C	thplace (State or Foreign ountry)
۵	Director		242-58-5010		69 Yrs.			Jan. 17	, 1937 Nort	h Carolina
	and	-	Usual Residence of Decedent 10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. City, Town or I	ocation				10d. Inside City Limits
	Manyl f ehc	ŏ,	Mana 1 and 1 Donaton			Conit	al Hadal	.+0		1X Yes 2 ☐ No
	the 28a-	Directo	Maryland Prince 10e. Street and Number	e George's	5	10f. Zip Code	ol Heigh	ILS	10g. Citizen of What C	ountry?
	3a or		1000 Shady	z Glen Dr	ive		20743	3	United	States
	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or Itema 23a or 28a-f ehow ent, the Medical Executive Calat be notified at	Funerai	11. Marital Status	12. Was Deced		. Was Decedent of I	Hispanic Origin?	(Specify Yes or No	- 14. Race - Ame	
LO.	and and and and and and and and and and	F	1 Never Married 2 Married	Armed Ford	2 □ No			erto Hican, etc.)		te, etc.
ğ	ours a	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dat	tes:	1 ☐ Yes 2 🗓 No	Specify:		Specify:	31ack
2	72 ho	Completed by	15. Decedent's (Specify only highest	Education grade completed)	16a. Dec	edent's Usual Occu e kind of work done	pation during most of w	orking	16b. Kind of Business	/Industry
2	ithin ne.	du	Elementary/Secondary (0-12)	College (1-	4or 5+) life.	DO NOT use retire	•		_	
2	ygier ygier tt, tr	Ö		5		Carpent	T	(F) 141-4-1-		rnment
Baltimore, Maryland 21215-0036	be fill had off	Be	17. Father's Name (First, Middle, La				18. Mothers N		Maiden Sumame) Mae Teel	
<u> </u>	Mer Marke Parke	2		Lount, Sr			4 4 44			7:0-10
<u>a</u>	nand raum		19a. Informant's Name/Relationship Nina B. Hooks			Ing Address (Street			er, City or Town, State, NC 27834	
e)	1 and Health		20a. Method of Disposition		20b. Place of Disp		Edite, of	Date	20c. Location - City or	
Jor	if to the or or or or or or or or or or or or or		1 🖫 Burial 2 ☐ Cremation 3		tate cemetery, cr	ematory or other pla				
Ħ	t Pa		4 Donation 5 Dother (Spe			Veterans 22. Name and Addre		the second secon	Cheltenha Funeral Ho	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, tra Modical Extra liner is and be notified at once.		21. Signature of Funeral Service Li	Lewat	XIII				Wash., DC	
4	7× / 10 3/1		23a. Part1. Ent r the disease, or co	omplications that ca	used the death. Do not e	nter the mode of dy	ing, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between
	Physician		shock, ir heart failure. List or Immediate Cause (Final	FATA		c ARR	HYTHML	A		Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (c	or as a consequence of):	7,040	HYTHM I EASE			
	Examiner			Coro	NARY ARTE	RY DIS	EASE			
		ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (c	or as a consequence of):					
	cuted Id ansit	Examine	Cause (Disease or injury that initiated events	G.						
ó	exection and and and and and and and and and an	EX	resulting in death) Last	Due to (o	or as a consequence of):					
8760,	cate be executed physicien and the burial-transit	Cai		d						
Ó	ntifica ng pt	Med	IF FEMALE:							
Вох	The law requires that the death certific tie has been signed by the atlending p bage 2 should be detached for use as i	Physician/Medicai	23b. Was decedent pregnant		ome of pregnancy th 2 Petal death 3	☐Ectopic pregnance	су		23d. Date of de Month	livery Day Year
O. E	e dea he at	sici	in the past 12 months? 1 Yes 2 No	4☐Pregna 9☐Unknov	int at time of death 5	Other (specify)			Month	Day rear
<u>а</u>	at the	Phy	9 Unknown					On Did		- 11
Ś	igner bed	by	Part II. Other significant condition	s contributing to dea	ath but not resulting in the	underlying cause gi	ven in Parti.		obacco use contribute t	robably 4 Unknown
ord	w require been sig	ted						. ''	Yes 2 No 3 P	
ec	has by	npie						24a. Was autor	prior to	utopsy findings available completion of cause of
<u> </u>	The sate h	Completed						1 ☐ Yes	ormed? death? 2XNo 1 ☐ Ye	2 □ No
ita Ita	iician: Thi certificate rector, pag	Be	25. Was case referred to medical examiner?	11				eath (Check only o	one)	
5	hysi this c	၉	1 ☐ Yes 2X No		patient 2 ER/Outpati	BIIL 3 L DOX			dence 6 Other (Spe	ocify)
L C	ding P. h. After I	ü	27. Manner of Death 1 ⊠Natural 5 □ Pending		f Injury 28b. Time n, Day Yeer) Injury	Wo		28d. Describe	how injury occurred	
Sic	death death ctor: /	cat	2 Accident investigated and Suicide 6 Could not	t he	of Injury At Laws 6]Yes 2 □No	29f Location /	Street and Number or R	- I Courte Mirror
Division of Vital Records,	or Attending Physician: after death. Director: After this certificd I in by the funeral director, I	Certification:	4 Homicide determin	ed 286. Place of buildin	of Injury - At home, farm, : g, etc. <i>(Specify)</i>	street, ractory, onice		City or To		urai Houte Number,
	pital purs a eral (29a. Certifier 1 Certifying	Physician: To the	best of my knowledge, de	ath accurred at the f	and data and ala	and due to the	Sauce/o) and minutes	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical			sis of examination and/or					
	To the within 2 To the Complet	Me	29b. Signature and title of partifier	-1		29c. Licen	se number		29d. Date signed (Mon	th, Dey, Year)
	+ 3 F ŏ		1	//11		7	58951		1-116	0/0
,	0		30. Name and address of person	no completed cause	o of death (Item 23a) (Typ	e Print)	00 10 1		1 14-6	10
1	LU		Do Callov I Tit	134	AL HOSPITAL	DRIVE	/	HEVERLY,	1-14-0 MD 2018	5
	Sta	te.	31. Date filed (Month, Day, Year)	₽. Re	egistrar's Signature	- 011/10		TICITAL!	- 30,00	-
	Regist		JUL 1 9 20	06	in the April	when the same				

DHMH 17 Rev 1/2001

ORIGINAL

Ronald Blackmen 06-04790

Please Type or Print in Black Indelible Ink

	1- For State Registrar	of Maryland / Department of Certificate o		Reg No. 2	006 2425
Physician/ Medical Examiner	Decedent's Name (First, Middle, Las ROWLAND	Rowland Moses Blackman		2. Date of Death Month Day Y July 7, 2006	3. Time of Death 0645 hrs
and the same of th	4a. Facility Name (if not institution, give 5706 Sargent Road	e street and number)	4b. City, Town, or Location of Death Hyattrsville		y of Death George's
Funeral Director		x 7. Age (In yrs. last birthday) (M 2 F 28 Yr	If Under 1 Year If Under 24Hrs Months Days Hours Min.	8 Date of Birth (MM/DD/YYY SEPT . 17 19	Foreign WASHINGTON
any	Usual Residence of Decedent 10a State 10b. County	10c. City, Town or Loca	tion		10d Inside City Limits
the Maryland or 28a-f show iffed at once. Director	MD PRINCE (GEORGE'S HYATTSV	ILLE 10f. Zip Code	10g Citizen of V	1 X Yes 2 No What Country?
th the Ma 23a or 23 notified a	6005 EASTERN AVEI		20783	U.S.	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		Armed Forces? If 1 Yes 2 X No If Yes, Give Year or Dates: 1	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto Yes 2 X No specify:	Rican, etc.) Wh	ce - American Indian, Black, lite, etc. :: BLACK
21215-0036 uld be filed within 72 hours after de Mental Hygiene marked other than "natural", or e event, the Medical Examiner mu To Be Completed by Fu	15. Decedent's Education (Specify or Elementary/Secondary (0-12)		nt's Usual Occupation (Give kind of v nost of working life. DO NOT use retii		Business/Industry
21215-0036 uld be filed within 7 Mental Hygiene wared other than everte, the Media	17 Father's Name (First, Middle, Last) RICHARD BLACKMAN			(First, Middle, Maiden Surnam	ne)
MD 21; d 2 should E Ith and Men 11 is mar 12 is mar To E	19a Informant's Name/Relationship (TWILMA BLACKMAN/MO		ng Address (Street and Number or F		· · · · · ·
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and A Important: If item 27 is n injury or other traumatic.	20a Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Specify 21 Signature of Funeral Service Licen	Removal from State crematory or c	COLN CEMETERY 7/2		n - City or Town State EWOOD, MARYLAND INERAL HOME
ໝັ້ນ ຢູ່ ຢູ່ ເຂົ້າ Physician	23a. Part I Enter the disease, or comp failure. List only one cause on ea	lications that caused the death. Do not enter	474 LANDOVER ROAD	LANDOVER, MAI	RYLAND 20785
/Medical Examiner	Immediate Cause (Final disease a.	Hanging Due to (or as a consequence of):			Death
red Insir Examiner	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
60, ate be execut hysician and burial - trai		AMENDED item#1.perME.g858	.8/3/06 TT		
Box 68760 e death certificate the attending phys ed for use as the b hysician/Me	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of death 5	etal death 3 Ectopic pregna	ancy 23d. Date Month	of delivery Day Year
P.O. Bc that the de- inned by the a detached for by Phys		§ 9 Unknown contributing to death but not resulting in the	underlying cause given in Part I.		ntribute to the cause of death? 3 Probably 4 Unknown
Division of Vital Records, P.O. Box 68760, tal or attending Physician: The law requires that the death certificate be executed as after death. In Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transit ertification: To Be Completed by Physician/Medical Ex		-		24a. Was an autopsy performed?	Were autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No
ital Fician:	25. Was case referred to medical examiner?	lospital: 1 Inpatient 2 ER/Outpatier	26 Place of Death (Check of the state of DoA Other Warsin		✓ Other Scene
rn of VI dring Phys h : After thii e funeral di	1 V Yes 2 No 27. Manner of Death Natura 5 Pending	28a. Date of Injury FOUND: POUND: FOUND:	Injury 28c Injury at Work?	28d. Describe how injury occu Subject hanged self	
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate I completely filled in by the funeral director, page ledical Certification: To Be Com	2 Accident Investigati 3 Suicide 6 Could not determine	be 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.	28f. Location (Street and Num or Town, State) 5706 Sargent Road, Hy	nber or Rural Route Number, City
To the Hospital within 24 hours To the Euneral completely filler	29a Certifier 1 Certifying Physic	ian: To the best of my knowledge, death occi- con the basis of examination and/or investig and manner stated	urred at the time, date and place, and	due to the cause(s) and mann	er as started
To vi i	29b Signature and title of certifier	and That the Stated	29c. License number O.C.M.E.	29d. Date sig July 7, 20	gned (Month, Day, Year)
2 (5)	30 Name and address of person who Laron Locke MD. Assis:	completed cause of death (Item 23a) tant Medical Examiner 111 Pen	n Street, Baltimore, MD 212	01	
State Registrar	31. Date filed (Month, Day, Year)	Registrar's Signature	K,		

OCME 2006

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Curtis Pilanala Bo		1- For State ND#18	perFH,7	e of Maryla /28/06 , DP	and / De S,McCo C	partmei <i>ertificat</i>	nt of H te of D	ealth and eath	d Menta	l Hygien	e Reg		06	2425
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,La Piianai	ast)	enfiel					Mont	of Death th [24, 200			Time of Death 1234 hrs
()		4a Facility Name (if n Shady Grove		ive street and no	ımber)			city, Town, or ockville	Location of E	eath		4c. County of Montgom		
Funeral		5. Social Security Nur		Sex	7 Age (In yr	s last birtho	_	Under 1 Year			te of Birth	(MM/DD/YYYY)	9 Birthp Foreign	lace (State or
Director		490-92-629	92 1	X M 2 F	2	21	Yrs.	Months Days	Hours	Min. Ma	y 30,	1985		ry) MO
any	F	Usual Residence of D 10a. State 10	Decedent Ob. County		10c. C	City, Town or	Location						10	Od Inside City Limits
*	_	Md.	Montgo	mery	G	aithe	rsbur	g					1	Yes 2 X No
vfarylar 28a-f d at on	ector	10e. Street and Numb	per				10	f. Zip Code			10g	Citizen of Wha	t Country	?
ith the Maryland 23a or 28a-f show notified at once.		28 McDona	ld Chap						878			United		
death wil	uneral	11. Marital Status1 Never Married	2 X Marrie		cedent Ever in orces?	1		ecedent of His specify Cuban				14 Race - White,		n Indian, Black,
safter or ral", o	Dy F	3 Widowed		ed If Yes, Give Ye or Dates:	ar 2005 –	2005		s 2 X No		4 - 6	. .	Specify:		easian
2 hours		15. Decedent's Educ			de completed 1-4 or 5+)			Jsual Occupat of working life.			ie 1	6b. Kind of Bus	iness/Ind	ustry
036 ithin 7 ne r fhan tedica	ompleted	12	, ,		ŕ	Aı	chit					Constr	ıctio	on
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once	0	17. Father's Name (Fi										iden Surname) Dilmei	Oshi	ma
212 rould by d Ment d Ment is mark	ToB	19a. Informant's Nam					_					er, City or Town	, State, Z	p Code)
MD and 2 shc and the and 2 shc and 2 shc and 27 is raumati		Dilmei Bo		eld (Mo				Court (Name of cer		hersbu Date		Md . 208	378 City or To	wn State
altimore, mit Pages I at partment of Her prortant: If ite	.	1 X Burial 2		3 Removal f	rom State	cremator	y or other	olace) iven Ce	-	July 31 2006	i,	Silver	•	
altim nit. Pa sartmen sortant	$\left \cdot \right $	4 Donation 5 21. Signature of Fund				Jacc 0						al Home		
Ba Peni	11	Curto	E. A	by	<u></u>		10	east De	eer Pa	rk Dr.	Gai	thersbu	rg, N	id. 20877
Physician /Medical		23a. Part I. Enter the failure, List only	one cause on	each line.			enter the n	node of dying,	such as card	flac or respira	atory arres	t, shock, or hea	t	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Find or condition resulting		a. Cardia Due to (or as										Death
	<u>.</u>	Sequentially list cond if any, leading to imm		b. Due to (or as	a consequenc	ce of):								
	Examiner	cause. Enter Underly	ying Cause	c-										
uted nd ransit		events resulting in de	usulting in death) Last Due to (or as a consequence of): d.											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ledical	X UNPENDED		AMENDED	item#2	23a, 27	, per l	ME, G860	, 10/5/	06 TT				
6876C certificate nding phys	n/Me	IF FEMALE: 23b. Was decedent pr		23c. If yes 1 Live	outcome of p	oregnancy 2	Fetal	death 3	Ectopic p	regnancy		23d. Date of o	delivery Day	y Year
ords, P.O. Box 6876 A requires that the death certificate S been signed by the attending phy should be detached for use as the	Physician/M	past 12 months?			nant at time o		Other	(Specify)				k		
D. B.		Part II. Other signific		19 JOHKI		not resulting	in the unde	erlying cause (given in Part	1 23	e. Did toba	acco use contrit	oute to the	cause of death?
, P.O res that t	d by		<u></u>							_ 1	Yes	2 No 3	Probab	ely 4 🗸 Unknown
ords A requi	Completed	i								24	a. Was an autopsy	/ pr	ior to con	osy findings available apletion of cause of
tal Recor	Som									1	perform Yes 2		eath? Yes	2 No
ician: s certifi rector,	Be (25. Was case referre examiner?	ed to medical	Hospital:	Inpatient 2	ERIOUS	enstiant 2		Other	heck only one lursing Home		esidence 6	Other:	
n of Vital Records, Ling Physician: The law requir After this certificate has been si funeral director, page 2 should t	-T	1 Yes 2 27. Manner of Death	No	1 '-	e of Injury	استا	ime of Injur		ry at Work?			w injury occurre		
ion tendin eath.	atior	1 X Natural 2 Accident	5 Pending	g	ii, Day, real)			1,	Yes 2 N	0				
Division spital or Attendin nours after death neral Director: A	Certification:		6 Could r	ot be 28e. Pla		At home, far	m, street, f	actory, office t	ouilding, etc.		cation (Str Town, Sta		r or Rural	Route Number, City
Tospita 4 hours "uneral		4 Homicide 29a. Certifier		ned (Specify		vledge deat	h occurred	at the time, d	ate and place	e, and due to	the cause	(s) and manner	as started	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	(Check only one) 2 V	Medical Exami	ner:On the basis	of examination	on and/or in	vestigation	, in my opinior	n, death occu	rred at the tin	ne, date ar	nd place, and du	e to the d	ause(s)
F 3 F 8	Me	29b. Signature and ti	itle of certifier					29c. Licens				29d Date signe		, Day, Year)
		20 Nome and add		*-	uso of docate	Itom 2221		O.C.	IVI. □.			July 27, 200	,o	
		30. Name and addres		Medical Exa			Street,	Baltimore,	MD 2120	1				
Si Regis	tate	. 100	JLay, Year) 8	2006 32. F	ogistrar's Sig	nature	6000	W						
1.0913	-			- 4										

			1 - For Amend item#20b-	State of l	Maryland/ Pe	partment of ertificate of	f Health a	and Me	ental Hyg	giene	006	242	55
			Registrar 1. Decedent's Name (First, Middle, Last)		erinicale c	Dealii		2. Date of Dea	Reg. No.	000	3. Time of D	
	Physici	an		iss.					Month July	Day 16,	2006	8:15	p ^M
	/Medic Examin		4a. Facility Name (If not institution, give		er)	4b. City, Town	n, or Location of	of Death	oury_		ounty of Death	0.13	_ <u>P</u>
	LXUIIII		Potomac Valley Nu	rsing H	ome	Rockv	ille			M	ontgome	ry	
	Funeral Director		547-18-2975	x 7. □M 2 ⊠ F	Age (In yrs. last birthda 93 Yrs.	Months Day		Min.	8. Date of Birtl (Month, Day Sept.]	Year)	9. Births Cour 12 Oh	ilace (State or itry) 10	Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					1	0d. Inside City	Limits
	f sho	ō	Maryland Montgome	rs	Bethes							1⊠Yes	
	28a-	rect	10e. Street and Number	ТУ	Deches	10f. Zip Cod	е			10g. Citize	n of What Cour	ntry?	
	N with	<u></u>	5416 Albia Road			2081	6			Un	ited St	ates	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f show amounts in iting or the results of the Maryland and once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	⊠ No	3. Was Decedent of If Yes, specify C			city Yes or No- Rican, etc.)		Race - Americ Black, White, pecify: Whi	etc.	
Š	2 hou	ted	15. Decedent's Edu	cation		cedent's Usual Oc				16b. Kind	of Business/In		
215	hin 7 9. Mad	ple	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4	life	ve kind of work do . DO NOT use rel	ne during most tired)	t of workin	g				
2	ad wit giene ar tha t, the	Completed		4		ctress					eater		
Maryland	be filk tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle,	Maiden Su	ımame)		
Уa	ould Men Parka	²	Omar Carl Kiger						ree Web				
Mar	12 sh h and 7 is m rraum		19a. Informant's Name/Relationship (T)		112	iling Address (Str				-		Code)	
e,	1 and Healt am 2 than 1		Julia C. Bliss /	Daugnt	20h Place of Dis	Albia R			da, Mar		1 ZUSI6	wn State	
Baltimore,	nt of it.		1 ☐ Burial 2 🖾 Cremation 3 ☐ F		ate Loudon P	ark Cenete oIn Crem	place) Ty	7/ 20 /			nore,		1
턡	artme prisant in injury	l A	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Serylee Licens 										10
Ba	Depire Impo) 1/~ X (4	S	22. Name and Ad imple Tr 040 Rock	ibute F	uner	al and	Crema	ation C	enter	: 2
	Friysician /Medical Examiner		23a. Part 1. Enfer the disease, or composhock, of heart failure. List only of immediate Cabse (Final disease or condition resulting in death)	_Demen	sed the death. Do not e h line.							Approximate Interval Betwee Onset and De Years	een
8760,	cate be executed physician and the burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying	o	as a consequence of): as a consequence of):								
.O. Box 6	death certifi e attending ed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		n 2 ☐ Fetal death 3 t at time of death 5	3 □Ectopic pregna 5 □ Other (specify,				230	d. Date of delive Month	ny Day Ye	ar
ecords, P	quires that the de n signed by the a lid be detached f	by	Part II. Other significant conditions co	ntributing to deat	h but not resulting in the	underlying cause	given in Part I.				contribute to the		
\mathbf{x}	ysician: The law requires that the is certificate has been signed by th director, page 2 should be detache	Completed							24a. Was a autops perform	sy med?	death?	psy findings av npletion of cau	
Vital	ician: Th certificate ector, pa	Be	25. Was case referred to medical examiner?	dosnite!				of Death	(Check only or	ne)			
Division of \	ding Ph h. After th funeral	tion: To	1 ☐ Yes 2 ☒ No ☐ 6 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 □ Inp 28a. Date of I (Month,	atient 2 ER/Outpat njury 28b. Time Day Year) Injury	of 28c. Ir	Other: 4 \(\times\) Null njury at Work? \(\times\) Yes 2 \(\times\) 1	28	le 5 ☐ Reside Bd. Describe he			7)	
Divisi	i Diffe	Certification:	3 Suicide 6 Could not be determined	28e. Place of building	Injury - At home, farm, etc. (Specify)	street, factory, office	се	28	8f. Location (Si City or Town		lumber or Rura	l Route Numbe	91,
	To tha Hospital within 24 hours a To tha Funeral Completely filled	edical	(Check only 2 Medical Exami	sicien: To the be ner: On the basi and manner	est of my knowledge, de s of examination and/or stated.	ath occurred at the investigation, in m	e time, date and ny opinion, deat	d place, ar th occurre	nd due to the c d at the time, d	ause(s) an late and pl	d manner as st	ated. the cause(s)	
	To the within To the comple	Σ	29b. Signature and Mile of certifier	00	- Ma	29c. Lice	ense number		2	9d. Date s	igned (Month,	Day, Year)	
)	1		> puece	-21	will	M) D3	8262			Ju13	17, 20	006	
	\wp		30. Name and address of person who co		, , , , , ,								
			Anurita Mendhira			search B	lvd. #3	30; 1	Rockvil	1e, N	laryland	1 20850	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 19 2	006	istrar's Signature	partie							

06-05336

Jason Lee Baumgardner

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

ason Lee Daan		11. For State Certificate Registrar Certificate			eg No. 200	01.05
Physici	an/	Decedent's Name (First, Middle,Last)		Date of Deat Month	Dav Year	3. Fime of Death
Medical Exami		Jason Lee Baumgardner 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location	July 22, 20	4c. County of Death	1050 hrs
A. S.		Washington County Hospital	Hagerstown	TOI Death	Washington	
Funeral Director			Yrs. If Under 1 Year If Under		h(MM/DD/YYYY) 9. Birt Foreig 1983	hplace (State or n ^{untry)} Maryland
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
*	ō	Maryland Washington Cascade				1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number	10f. Zip Code		ng. Citizen of What Cour	-
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f shr or other traumatic event, the Medical Examiner must be notified at once		25467 Military Road 11. Marital Status 12. Was Decedent Ever in U.S 13.	21719 Was Decedent of Hispanic O		United Stat	
death v	Funeral	1 X Yes 2 No	If Yes, specify Cuban, Mexica	an, Puerto Rican, etc.)	White, etc.	
hours after "natural", Examiner	à	or Dates:	Yes 2 X No specification (Given's Usual Occupation (Given)		Specify: W1 16b. Kind of Business/li	nite
72 hour	eted		g most of working life. DO NO		TOD. KING OF BUSINESS/II	ldustry
21215-0036 build be filed within 72 Mental Hygiene. marked other than '	Completed		ntry Soldier		United Sta	tes Army
115-(Filed all Hyging of other of the	Be Cc	17. Father's Name (First, Middle, Last) Wayne David Baumgardner		er's Name (First, Middle, M ori Joseph	faiden Surname)	
2121 ould be fi d Mental I s marked	To B		iling Address (Street and Nu		ber, City or Town, State,	Zip Code)
e, MD 21215-003 I and 2 should be filed within Health and Mental Hygiene, item 27 is marked other the			57 Military Roposition (Name of cemetery,	l., Cascade,	MD 21719 20c. Location - City or	Foun State
Baltimore, MD 2 semit Pages I and 2 shou Department of Health and N important; If item 27 is in njury or other traumatic		1 Burial 2 X Cremation 3 Removal from State crematory or	other place)	July 28,		
Baltimore permit Pages I Department of F Important: If		4 Donation 5 Other Specify: Resthave 21 Signature 2 e Licensee	n Crematory 2 Name and Address of Facil esthaven Fune	2006	Frederick,	Maryland
Perr Dep Linition	1	1/1/	501 Catoctin :	Mtn. Hwv. Fr	ederick. MT	1y P.A. 0 21701
Physician /Medical		23a. Par Enter the dis le, or complications that caused the death. Do not enter failure. List only one cause on each line.	er the mode of dying, such as	cardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple injuries Due to (or as a consequence of):				Deam
	L	Sequentially list conditions, b.				
4	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
ited d ansit	Exa	events resulting in death) Last Due to (or as a consequence of): d.				
sto, te be executed ysician and burial - transit	Medical	T UNDENDED AMENDED	-f,perME,g860, 10	0/12/06 TT		
3760, ficate be g physicist the buri		IF FEMALE: 23c If yes, outcome of pregnancy		pic pregnancy	23d. Date of delivery Month D	
Box 687 e death certific the attending p	sician	past 12 months? 4 Pregnant at time of death 5	Fetal death 3Ector Other (Specify)	ore pregnancy	IMOTAL D	ay Year
H a 4 3	Phys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in l	Part I. 23e. Did to	bacco use contribute to t	he cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	ģ		, , ,		2 No 3 Prob	abiy 4 Unknown
ords, P w requires t is been sign should be o	Completed			24a. Was a autops		opsy findings available ompletion of cause of
Reco	E O			perform 1 🗸 Yes 2		s 2 No
ital Recionaria The scertificate	æ	25. Was case referred to medical examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpati	Othor	h (Check only one) Nursing Home 5 I	Davidanas & Other	
n of Vi ding Phys 1. After this funeral di	2	1 ✓ Yes 2 No III patient 2 Errought 27. Manner of Death 28b. Time (Month, Day, Year) 28b. Time			Residence 6 Other:	
ion trendin death. tor: A	atior	Natural 5 Pending 7/16/2006 4:05	am 1 Yes 2	X No unk		
Divis all or At after of Directed in by	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, s	street, factory, office building,	or Town, St	treet and Number or Runtate) I-70 near 7	al Route Number, City Mile Marker
D To the Hospital within 24 hours To the Funeral completely filled	Ce	29a. Certifier 1 Certifiting Physician. To the best of my knowledge, death or	ccurred at the time, date and r	Hancock		ed
To the I within 2 To the I	edical	one) 2 Medical Examiner: On the basis of examination and/or invest and manper stated				
E > E o	ž	29b. Signature and title officertiffer	29c. License numbe	er	29d Date signed (Mon	th, Day, Year)
N/A		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		July 25, 2006	
1/1/4			enn Street, Baltimore,	MD 21201		
S Regis	tate	31. Date filed (Month, Dal Mear) 8 200 32. Registrar's Signature	Smarth			
Regis	ueli		7			

		,	For State Registrar		State of	Marylan		artmen <i>rtificat</i>			Mental Hy	giene	006	24257
			1. Decedent's Jame (First, Middle,	Last)		0				2. Date of De		V	3. Time of Death
	Physici /Medic	_	1the	Seul	7		BAR	2P-1	TNE	SER	Month	14	ZČOU	1140AM
	Examir		4a. Facility Name (If no	ot institution,	give street and numb	er)				ocation of Dea	th		inty of Death	
101		x cc			ed Living			_		na Park			nne Ar	
14 m	Funeral		5. Social Security Num 220-03-05		5. Sex 7. 1 ☐ M 2 🛣 F	Age (In yrs.	last birthday) Yrs.	If Under Months	Days	Hours Min	. (Month, D	rth ay, Year)		place (State or Foreign ntry)
	Director		Usual Residence of De			87					Feb. 2	6, 191	9	MD
	yland			0b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Marie 1	tor	MD	Anne	Arundel			5	ever	na Park				1 ☐ Yes 2 ☑ No
	death with the Maryland me 23a or 28a-f show f must be motified at)ire	10e. Street and Numb	er .				10f. Zip				10g. Citizen		•
	23a	rai	41 McKinse	ey Road					211					JSA
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar t of Health and Mental Hygiene. If Item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 3 🛛 Widowed 4		12. Was Deceded Armed Force d 1 Tes 2 If Yes, Give Year or Date	es? ₩No		Was Deced f Yes, sped 1 ☐ Yes		panic Origin? () , Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	ľ	Race - Ameri Black, White, ecify: Wh	
2-0	72 ho	Completed		5. Decedent's	Education grade completed)		16a. Deced	dent's Usua	al Occupat	ion Iring most of we	orkina		f Business/Ir	
2	within lene. than "	nple	Elementary/Second		College (1-4	or 5+)	life.	DO NOT us	se retired)		······ y	Soci	al Sec	curity/
	Hygier Hygier other th		10 17. Father's Name (Fil	mt Middle L	201		CI	erk/H			me (First, Middle	Maiden Sug	Home	
Maryland	ntal Hed of	Be	Charles I								Breighne		iaiiie)	
7	2 should be of and Mental I is marked or raumatic eve	ပ	19a. Informant's Nam				19b. Mailir	ng Address	(Street a		tural Route Numb		wn, State, Zij	p Code)
Ma	od 2 s lith ar 27 ls r trau				rhusen/Dau	ghter	359	Greer	Asp	en Cour	t, Mille	rsvill	e, MD	21108
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra once.		20a. Method of Dispos 1 → Burial 2 → 6 4 → Donation 5	Cremation 3	3 □Removat from Sta	ate C	Place of Disponentery, cremetery, cremetery	natory or o	ther place		July 17, 2006		on - City or T	
Balti	permit. Pa Departmen Important: any Injury once.		21 Signature of Fune	-		Som	/ ²² B	. Name an	d Address	of Facility Sons,		erna P	ark Fu	neral Home D 21146
The second second	Physician /Medical Examiner	Examiner	23a Enter the shock, or heart immediate Cause (Fidisease or condition resulting in death) Sequentially list condition and the sequentially list conditions. Enter Underly Cause (Disease or injudat initiated events	ailure. List o	Due to (or	h line.	TIVE uence of):		, -		LURE			Approximate Interval Between Onset and Death PARS
O. Box 68760,	ne death certificate be executed the ettending physicien and thed for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent p. in the past 12 mt 1 Yes 2	regnant	d	n 2 ∏ Feta it at time of d	ancy]Ectopic pr] Other (sp					Date of deliv	ery Day Year
ds, P.O.	ss that the	d by Ph	Part II. Other significa	ant condition	s contributing to deal	th but not resi	ulting in the u	nderlying c	ause giver	n in Part I.		tobacco use c		the cause of death?
Recor	e law has b	Completed by	Seiz	ure	D1501	2001	R				24a. Was auto perf		b. Were auto prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of
ita	ilcian: Th certificate rector, pag	Be	25. Was case referred examiner?	to medical							eath (Check only	one)		
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	2	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident	5 Pending	ition		ER/Outpatier 28b. Time of Injury		8c. Injury Work	4 Li Nuising	Home 5 ☐ Res 28d. Describe		Other (Speci curred	MASSISTED LIVING
Divis	ital or Att rs after de ral Direct	Certification:	4 Homicide	6 Could no determin	ned 286. Place of building	, etc. (Specif					City or To	wn, State)		al Route Number,
	the Hosp in 24 hou the Funer ipletely fil	Medicai	(Check only 2 one)	_ Medical E	Physician: To the bas xaminer: On the bas and manne	is of examina	wledge, deati	vestigation	, in my opi	nion, death occ	e, and due to the surred at the time,	date and plac	ce, and due t	o the cause(s)
	To To com	2	29b. Signature and tit	e of ceptifier	al A	fr	In M.	2	D2		,0	JVLY	gned (Month,	2006
			30. Name and addres	EL	ANXROV	N MI	860	Print)	0.701	rans/	1161+W1	y MIL	LERSVI	ue MOZIOS
1	Sta Regist		31. Date filed (Month,	AATO A	7 2006 32. R	istrar's Signa	ature	Land				,		

			For State Registrar	State	of Ma	ryland / Do	epartm C <i>ertific</i>	ent of F ate of	lealth Deat	and M h	ental Hy	/giene Reg. No	- C U U L	5 2425	8
	Dhunini		1. Decedent's Name (First, Middle	, Last)							2. Date of De Month		v Year	3. Time of Death	
	Physici /Medio		Marie Olivia Ba	ker							7	18 ^{Da}	^y 2006	11:16A M	
	Examin		4a. Facility Name (If not institution	, give street and no	umber)			ity, Town, o	r Locatio	n of Death		4c	. County of Dea		
Н			120 Cedar Ave.		T	/h		erlin	If Had	er 24 Hrs.			Worcest		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age	(In yrs. last birth	Mont		Hours		8. Date of Bi (Month, D	ay, Year)	9. Bir	thplace (State or Foreign ountry)	
	Director		215-07-8373 Usual Residence of Decedent			97 Y			1		3/28/	1909		MD	-
	/land		10a. State 10b. County			10c. City, Town	or Location							10d. fnside City Limits	
	Man Hind	ţo	MD Wor	cester		Berli	n							1 ☐ Yes 2 No	
	or 28e	Director	10e. Street and Number				10f.	Zip Code				10g. Cit	tizen of What Co	ountry?	
	th wit	aiD	120 Cedar Ave.					21811					USA		
	within 72 hours after death with the Maryland ene. then "natural", or itema 23e or 28e-f ehow La Medical Examicar mast be mailfied at	Funeral	11. Marital Status	12. Was Dec		ver in U.S.	13. Was De	cedent of H	lispanic (Origin? (Spe	cify Yes or N	0-	14. Race - Ame Black, Whit		
õ	or it	by Fu	1 Never Married 2 Marr	ied 1 ☐ Yes If Yes, G	2 ∑ No iive	0		s 21⁄2 No	Speci		, , , , , , ,		Specify: wh		
2-003p	ural',		3 Widowed 4 Divorced	Year or I	Dates:	10.5									
ι Γ	"nat	Completed	15. Deceden (Specify only highe)	(6	ecedent's l Give kind of ife. DO NO	work done	durina m	ost of worki	ng	16b. K	and of Business	/fndustry	
717	within ene.	ᇤ	Efementary/Secondary (0-12)	College	(1-4or 5+	-)		Serv	,				School S	System	
0	filed Hygi other	a)	17. Father's Name (First, Middle,	Last)			1004	Derv		ther's Name	(First, Middle	4		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	_
yland	ild be lental ked ic ev	To B	Edward Dunn							Teresa	a Ritte	er			
ar	shou and N man		19a. Informant's Name/Relations	hip (Type, Print)		19b. M	Mailing Add	ess (Street	and Nurr	nber or Rura	l Route Numb	oer, City o	or Town, State, .	Zip Code)	
<u>Z</u>	alth alth 27 is		Douglas C. Bake	r (husba	nd)	12	0 Ced	ar Av	e.,	Berli:	n, MD 2	21811			
9	of He		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation	2 Damoual from	Ctata	20b. Place of D cemetery,	isposition (Name of or other place	сө)	C	ate	20c. L	ocation - City or	Town, State	
Ĕ	Page nent ant: If ury o		4 Donation 5 Other (S		1 State	Evergr	een C	emete	ry	7/2	1/2006	Ber	lin, MI)	
Бапптог	permit. Pages 1 and 2 should be tited within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or itema 23a or 28a-f show way injury or other traumatic event, it a Medical Examiner must be notified at ance.		21. Signature of Funeral Service	Licensee	⊋ .			and Addre				_	Funeral		
Ц	40 E 8 a		Tacquel	ere)i	170	Herty							1D 21811		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	each line	the death. Do no	t enter the r	node of dyir	ng, such a	as cardiac c	r respiratory a	arrest,		Approximate fnterval Between Onset and Death	
	Physician		Immediate Cause (Finaf disease or condition	a_Fail	ure	to thri	ve							Oriset and Death	
	/Medical Examiner		resulting in death)			consequence of):			-					
		_	Sequentially list conditions,	b	ntia	eonsaquenea of	E-1								
	ted nslt	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		, (0: 45 4	, concequence of	,.								
	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a	consequence of):								-
a/on,	ficate be executed physician and s the burial-transit	dical		d											
0	tificat g phy as th	u u													
ŏ	death certif e attending od for use as	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or		of pregnancy	3/DEctori	c pregnancy				1	23d. Date of de	,	
	w requires that the death certif been signed by the attending should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ██No		nant at t	ime of death	5 Other		y 				Month	Day Year	
л Э	requires that the een signed by th hould be detache	hy	9 Unknown												_
ທົ	es the decidence of the	þ	Part II. Other significant condition	ns contributing to	death but	t not resulting in t	he underlyir	ng cause giv	en in Pai	rt I.			_	the cause of death?	
Cord	requi	ted									10	Yes 2	X_1N0 3 PI	robably 4 Unknown	
ď۵	er (0 o)	Completed									24a. Was	psy	prior to	utopsy findings available completion of cause of	
Ï		Ç									1 ☐ Yes	ormed? 2 132 No	death? 1 ☐ Yes	2 □ No	
VII	yeician: is certific director,	Be	25. Was case referred to medical examiner?	Hospital				DOA Oth			(Check only				
5	this ald	은	1 Yes 2 No 27. Manner of Death	1 _	Inpatien			DOA	4 🗀		ne 51 Res 28d. Describe		6 Other (Spe	cify)	4
	ding h. After fune	ţ	1 XNatural 5 ☐ Pendir		nth, Day	Year) Infi		28c. Injur Wor	rk? Yes 2		LOG. Describe	now inju	ry occurred		
UNISION	Atten deat ctor: y the	fica	3 Suicide 6 Could	not be 28e. Plac	e of Inju	ry - At home, farn	n, street, fac							ural Route Number,	_
5	spitel or Attending Fours after death. The and Director: After filled in by the funer.	Certification;	4 Homicide	build	ding, etc.	(Specify)					City or To	wn, State	e)		
	To the Hospitel of within 24 hours at Yo the Funeral Completely filled in	edical (29a. Certifier (Check only 2) Medical one)	g Physician: To th Examiner: On the	basis of	examination and/	death occur or investiga	red at the tir tion, in my o	me, date opinion, d	and place, a	and due to the	cause(s , date and) and manner as d place, and due	s stated. e to the cause(s)	_
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifie		nner stat			29c. Licens	e numbe	ır		29d. Da	te signed (Mont	h. Day, Year)	_
)	->-0		1 Adu					אַכּת	755			T ₁	ıly 18,	2006	
	4		30. Name and address of person	who completed cau	use of de	ath (Item 23a) (T	ype, Print)		, ,,,				-1, 10 ,	2000	_
1	1 2		Dr. Glenn Arz	adon, MD	971	4 Health	nway [r., B	erli	n. MD	21811				
	Sta		31. Date filed (Month, Day, Year)	32.	R gistra	r's Signature	door								
	Registr	ai	JUL 2	A CANO		, ,,	7								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** Ju₁y 9 2006 Cleo Calder 7:53 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 □ M 2 TF Yrs. 91 Director 578-18-8712 Apr. 3, 1915 South Carolina Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits ehow. the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director or 28e-f DC Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3298 Ft. Lincoln Drive, #525 or iteme 23a 20018 United States Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "naturel", or item eny injury or other traumatic event, the Madical Exemples. Black, White, etc. 1 Never Married 2 Married African 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Beautician Private Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Govenor H. Thompson Sustanchia Henderson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Althea Flack/Niece 3801 Massachusetts Ave., SE Wash., DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other biase)k 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National Mem. 7/14/2006 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland Stewart Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4001 Benning Rd., NE Wash., DC 20019 Part Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Immediate Cause (Final **Physician** disease or condition resulting in death) Myocardial Infarction 60 Minutes /Medical Due to (or as a consequence of): Examiner ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Years Due to (or as a consequence of). Physician/Medical Examiner anding physicien and use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 20 No certificate 1 Yes 1 Yes : After this certifical funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Japital c.
4 hours after dea..
-rel Director: Afr 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. pletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) ~000 X Del Vecchio who completed cause of death (Item 23a) (Type, Pri-t) 30. Name and address James A. Delvecchio, M.D. 1500 Forest Glen Rd., Silver Spring, MD 31. Date filed (Month, Lay, Year) 32. Registrar's Signature Registrar

		1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment rtificate	of Health of Deat	n and M th	lental Hy	giene Reg. No		242	60
Physici	ian	Decedent's Name (First, Middle, Last)						2. Date of De		Year /	3. Time of D	-
/Medic	cal	RONALD EDWARD	CHAPMAN		4h City T	own, or Location	on of Dooth	2416	1 3	County of Death	2015	DOM.
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Funeral Director			M 2□F 72	Yrs.	Months	Days Hour	s Min.	SEPT.	25,19	933 MAI	RYLAND	
and W		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					1	Od. Inside City	/ Limits
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23a	ral	12908 GROWDENVALE		0 140		502	0-1 1-0 /0-			.S.A.	an Indian	
ite; Mal ylail of ILI 3-0030 s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "naturel; or Iteme 23s or 28s-f show other traumatic event, the Modical Espainer must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 157—	1	was Decede If Yes, speci 1 ☐ Yes 2	ent of Hispanic fy Cuban, Mexi No Spec	can, Puerto	ecry Yes of No Rican, etc.)	0-	14. Race - Americ Black, White, Specify: WH		
72 hot	sted	15. Decedent's Educ	ation	(Give	kind of work	Occupation done during m	nast of work	ina	16b. K	ind of Business/In	dustry	-
Men "t	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	IITO.	DO NOT use	e retirea)	TOST OF WORK	9				
filed v Hygie ther t	e Co	17. Father's Name (First, Middle, Last)	5+	PRI	INCIPA		other's Name	e (First, Middle		EDUCATION Sumame)	V	
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2 should and Name is man and and and and and and and and and a		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address	(Street and Nur	mber or Rur	al Route Numb	er, City o	or Town, State, Zip		
and land leath mm 27			PMAN / WIFE	12908 lace of Dispo				N.E.,		BERLAND, ocation - City or To		.502
Pages nent of the int: # Ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	moval from State	emetery, crei	natory or oti	her place)	1					
그 등문을		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Usanse			2. Name and	Address of Fa	cility	/2006		AVIDSVILI	LE, PA	
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Physician /Medical Examiner	_	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Pulmonary Due to (or as a nonego	Fibros uence of):		of dying, such	as cardiac	or respiratory a	irrest,		Approximate Interval Betw Onset and D	een
cate be executed physicien and sthe burial-transit	dical Examiner	it any, leading to initractiate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence									
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quires that on signed by	Ď	Part II. Other significant conditions conf	tributing to death but not res	ulting in the u	nderlying ca	iuse given in Pa	art I.		tobacco (use contribute to t	V	ath? nknown
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To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify					City or To	wn, State			er,
Hospi 14 hou Funer Tely fill	Medical	29a. Certifier Certifying Phys (Check only one)	er: On the basis of examina	wledge, deat tion and/or in	h occurred a vestigation,	at the time, date in my opinion, o	and place, death occur	and due to the red at the time	cause(s date and) and manner as s d place, and due to	tated. the cause(s)	
To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c.	License numb	er		29d. Da	te signed (Month,	Day, Year)	<u></u>
11/,		1)1/2/4	-			D36766			(A	1.42	3,20	06
Ch 11		30. Name and address of person who con	mpleted cause of death (Item	n 23a) (Type,	Print)	, 1				,	1	
91 KD		JIK Pown 35 MD. 31. Date filed (Month, Day, Year)	-924 Sept	Dr	- Clerk	ber/2n	d, ou	D 219	502	2		
St Regist	ate	1111 2 6 2006	Togistial s Signa	do	alle s							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Year Month **Physician** 12:58 P [™] 13, LEONARD L. CHANEY JULY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY CUMBERLAND

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)

JAN. 26, 19 CUMBERLAND MEMORIAL HOSPITAL 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Funeral 1XM 2□F 78 Yrs. 1928 Director WEST VIRGINIA 234-40-2868 Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No CUMBERLAND Be Completed by Funeral Director MD ALLEGANY 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21502 14 EUCLID PLACE U.S.A. or items 23a 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 ☐ Widowed 4 X Divorced WHITE "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) EOUIPMENT OPERATOR CONSTRUCTION permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if Item 27 is marked other it any Injury or other traumatic event, ILLS QUE. 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) LUCY MAE GARLEND RUSSELL CHANEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 MAPLE STREET, RIDGELEY, WV PAUL CHANEY / BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition 1 ☐ Burial 2 TCremation 3 ☐ Removal from State CUMBERLAND CREMATORY 07/17/2006 CUMBERLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signaluy of Funeral Service Licensee, 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. ACRILLA 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** 2 lus /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events M Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and s the burial-transit agen resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical ettending pl 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? UPD 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificete 2 No 1 Yes 2□ No 1 Yes of Vital To the Hospital or Attanding Physician: within 24 hours after death.

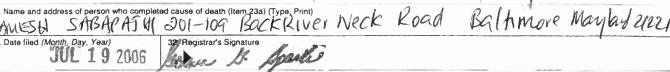
To the Funeral Director: After this certifice completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred Medical Certification; Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Cartifying Physician: To the best of my knowledge, death perumed at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 17, 2006 D0017505 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - 922 Huxy LaValo, MD nas MT Hathony 2. Registrar's Signature 31. Date filed (Month, Day, Year) 1 7 2006 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U U 5 1 - For State AMEND#26perMD7/18/06,BMW,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CARRERA. HENRY N. 17,2006 2.20AM フレーム /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Howard Howard County General Hospital Columbia Months Days Hours Min. 8. Date of Birth Month, Day, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1∰M 2□ F 578-20-2477 82 Washington, D.C. Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. Count 10a. State 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydene.
Important: if them 27 is marked other then "natural; or iteme 23a or 28a-f show any hury operative treumatic event, if a Medical Exaction treum the profiled at once. Maryland Howard Columbia 1 Yes 2 No Director 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 21044 6336 Cedar Lane, #178 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (9-12) College (1-4or 5+) President paint company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vasco Nicola Carrera Dorotea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12025 Sand Hill Manor Drive Marriottsville, Md. 21104 Susan A. Reising -daughter 20b. Place of Disposition (Name of cometery, crematory or other punion Cemetery 20a. Method of Disposition 20c. Location - City or Town, State or other place 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/20/2006 Burtonsville, Maryland 21. Signature of Funeral Service License Donald Vor Borgwardt Funeral Home, PA Moreld V 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Intraventricular hemorrhage Immediate Cause (Final C'erebellar and **Physician** disease or condition resulting in death) /Medical Cardiovascular Disease **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho this certificate has 2 No 1 Yes After this certification, funeral director, p 25. Was case referred to medical 26. Place of Death | Check only one examiner? Dther: 4 ☐ Nursing Home 5 ☐ Residence 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending To the Hospital or Attendir within 24 hours attar death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No investigation 2 Accident the t 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier D 30641 V/aw

State Registrar 31. Date filed (Month, Day, Year) JUL 19



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			- State Registrar			C	Certificate of	Deat	h	Re	g. Nó.: UU	24263
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Christy 01 27 AM Marie 07 16 06 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Medical System Baltimore mD Univ. of MD If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct 16, 1940 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1□M 2XF 212-38-4760 65 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral', or items 23a or 28e-f show Examiner must be notified at 1 XYes 2 ☐ No Director Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901 Barnett Lane, Apt 101 21001 USA 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 XWidowed 4 ☐ Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Production Worker Manufacturing 12 and Mental Hygi injury or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event sone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth Allender Marie E. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 405 Chadsworth Court, Aberdeen, Maryland 21001 e of Disposition (Name of Date 20c. Location - City or Town, State Lisa Thompson / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Union United Meth Cem 7/22/06 Aberdeen, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Lisa Scott Funeral Home, P.A.

552 Lewis Street, Havre de Grace, MD 21078

Approximate shock, or heart failure. List only one cause on each line.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide to the cause (s) and manner as stated. The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Gandotra P19714 ed cause of death (Item 23a) (Type, Print) Greene 22 South Gando tra 9 2006 State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 11 11 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** unn 11:32 A July 26 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County Carroll Hospital Center Westminster If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2☑F Months 212-24-3453 1927 Maryland Director Usual Residence of Decedent 10a State 10b County 10c City Town or Location 10d Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.

shir! If item 27 Is marked other than "natural", or itema 23s or 28s-f show any or other traumatic event, its healtest Exacting its institute to configuration. Maryland Carroll County Union Bridge 1 Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 511 Shriner Court 21791 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specity: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) dry cleaner shirt presser 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles D. Warner Virginia Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other trai once. Cynthia A. Zepp / daughter Taneytown, Maryland 21787 P.O. Box 347 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State July 31 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Joseph's Cemetery Taneytown, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 2006 22. Name and Address of Facility 21. Signature of Funeral Service Licenshe Skiles Funeral Home 136 East Baltimore Street Taneytown, Md. 21787 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT KIGHT **Physician** 2 hours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Hoknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by demontra Alzhemerio 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

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ely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the th 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Juliesta 331660 07/26/2006 MAMOS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21157 WES DANSTER MALLIANS 2011 STOKER AVENUE THOMAS K. GALVIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 2 2006 Registrar

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27. Manner of Death 1	fv)					Othe	nt 3 D	ER/Outpatie	npatient 2[Hospital:			0	yelc.	<u>></u>
The state of the s						28c. Injury	of		of Injury	28a. Date				g Ph ter th	0
3 Suicide determined 3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural R City or Town, State)				Vo				(0.)	.,, ,	1	investigatio	2 Accident	atlo	ath.	<u>io</u>
	al Route Number,					ry, office	reet, facto			289. Plac			i i	er de recto	N N
													Ce	italo rsaft rai Di	
29a. Certifier (Check only one) 29a. Certifying Physician: To the blast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	tated. o the cause(s)	ause(s) and manner as stated. ate and place, and due to the c	ue to the cause the time, date a	d place, and the occurred a	e, date and inion, deal	d at the time in, in my op	th occurred evestigation	owledge, deal ation and/or in	sis of examir	niner: Oh the I	Certifying Pl	(Check only 2	dicai	• Hosp 24 hou • Fune etely fil	
and manufel stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day)	Day, Year)	9d. Date signed (Month, Day,	29d. (24 29	-015			of certifier	29b. Signature and title	Me	To th To th Somp	
	, 2006	July 18, 2	J	2	128.	D13			CM	lung	Jun VV) (DE)
R (3) Name and address of person who completed cause of death (Item 23a) (Type, Print) Alfred Munzer MD 7600 Carroll Avenue Takoma Park, M.				Je 10	Alen.	roll	Print)	m 23a) (Type,				A 1 C		(5)	R
State Registrar 31. Date filed (Month, Day, Year) The Registrar 31. Date filed (Month, Day, Year) The Registrar's Signature The Registrar's Signature		1			, , , , , ,			,					1		·

			1 - For State Registrar	State	of Mar	ryland		artmen <i>rtificat</i>				ental Hy	giene Reg. No.	C U (6 (242	267
	Shusiai		1. Decedent's Name (First, Middle	, Last)								2. Date of De			Year	3. Time of	Death
	Physicia /Medic		Bernice Louis	e_Darby									16		1041	18:41	P ^M
	Examin		4a. Facility Name (If not institution	give street and i	number)			4b. City,	Town, or	Location of	of Death		4c.	County of	f Death		
¥			Southern Mary						nton 1 Year	If Under	24 Hrs. 1	0.5				rge's	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🂢 F			ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da	ay, Year)			ntry)	r Foreign
	Director		577 44 9609 Usual Residence of Decedent			72						Feb 07	, 19	34 V	wasn	., DC	
	yland		10a. State 10b. County		1	10c. City	, Town or Lo	cation							1	0d. Inside Ci	ty Limits
:	a-1 s	ctor	MD Prince	George 1	s	Uppe	er Mar	1boro								1 🗌 Yes	2 X No
3	or 28	Director	10e. Street and Number	-				10f. Zip	Code				10g. Citi	zen of Wh	nat Cour	ntry?	
	23a	rai	9401 Concord						772					ed St			
	ite a	Funeral	11. Marital Status	12. Was De	Forces?		S. 13. V	Nas Deced f Yes, spec	tent of His city Cubar	spanic Ori n, Mexican	gin? (Spe 1, Puerto l	cify Yes or No Rican, etc.))-		 Americ White, 	ean Indian, etc.	
5	i, or	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes,	s 2√∏No Give r Dates:	,		1 🗆 Yes	⊉ No	Specify:				Specify:	B1	ack	
5	atura		15. Decedent	's Education			16a. Deced	dent's Usua	I Occupa	ition			16b. Ki	nd of Bus	iness/In	dustry	
2 2	nu and nu	Completed	(Specify only highes Elementary/Secondary (0-12)	1	ed) e (1-4or 5+))	life. i	kind of wo DO NOT us	rk done d se retired)	u <i>ring</i> mosi	t of work!	ng					
7	gr th	Son	8				Hou	sewif	e					Own I	Home	•	
2	d oth	Be	17. Father's Name (First, Middle, I	_ast)								(First, Middle		Sumame,)		
2	z snoud be lied within 72 hours arier death with the maryland and Mental Hygiene. Is marked other than "natural", or tiema 23a or 28a-f show sumatic avent, the Medical Examiner must be notilied at	2	John I. Dyson									Chane					
מום ו	s 1 and 2 should be lied within 72 hours after death with the marylan of Health and Mental Hygiene. If Health and Mental Hygiene. If Health and Mental Hygiene. Other traumatic avent, the Modical Examinar must be notified at		19a. Informant's Name/Relationsh					-				/ Route Numb	-				
ָ ט	Healt em 2		Bernida Willi 20a. Method of Disposition	ams		20b. PI	ace of Dispo emetery, cren					Marlb				wn, State	
	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		m State		emetery, crer ncoln				T111	20, 20			•		
	ortan finjur		21. Signature of Funeral Service I		A 0	1111		Name an	d Addres	s of Facilit	hv						
Ď	Depa Impo		1.7.9	Nous	bl	1		Mars 4308	hall Sui	's Fu tland	inera 1 Rd,	1 Home Suitl	of land,	Maryl MD 2	Land 2074	6	
			23a. Part1. Efter the disease, or shock, of heart failure. List	complications that only one cause of	it caused the n each line	he death	. Do not ent	er the mod	e of dying	, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Bety	veen
	hysician		Immediate Cause (Final disease or condition resulting in death)	a. 85	em c	ho	ger	Nic.	\mathcal{L}	are	CIN	omo	·			Onset and I	Эва(П
	/Medical Examiner		resulting in death)	Due t	to (or as a	consequ	ence of):										
		P	Sequentially list conditions, if any, leading to immediate	b	to (or as a	consequ	ience of):										
	ured ansit	Examiner	cause. Enter Underlying Cause (Disease or injury		,	·	,										
5	be executed icien and burial-transit	Еха	that initiated events resulting in death) Last	C. Due f	to (or as a	consequ	ence of):								_		
000	cate be executed physicien and the burial-transit	dical		d													
9	ing pt	Med	IF FEMALE:														
בא מ	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		e birth 2	Fetal	death 3	Ectopic pr					2	23d. Date Monti			ear
5	I ne law requires mat me deam cenino ate has been signed by the ettending p page 2 should be detached for use as i	Physician/Med	1 ☐ Yes 2 🔀 lo 9 ☐ Unknown	4 □ Pre 9 □ Uni	egnant at tir known	me of de	eath 5	Other (sp	ecify)							,	-
Ľ	ed by detac		Part II. Other significant condition	ns contributing to	death but	not resu	Ilting in the u	nderlying c	ause give	n in Part I.		23e. Did 1	obacco u	se contrib	ute to th	e cause of d	eath?
cords,	urres r sign ld be	d by	Chronic 8	shel	acti		L	مدا	de	000	-	10	Yes 2	□No 3	☐ Prob	ably 4	nknown
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<u> </u>	an: tifica tor, p	0	25. Was case referred to medical	y pe	xpr	Yel	171.5	440	PA	26. Place	of Death	1 ☐ Yes	2 Z No		Yes	2 140	
>	nysica lis ca direc	To B	examiner? 1 Yes 2 No	Hospital:	□Inpatient	2 🗷	ER/Outpatien	t 3 DC	A Othe	r: 4 □ Nu	rsing Hon	ne 5 ☐ Resi	dence 6	3 Other	(Specify	()	
	ng Pr		27. Manner of Death 1 ☑Natural 5 ☐ Pending		te of Injury lonth, Day Y	Year)	28b. Time of Injury	2	8c. Injury Work	at ?	2	8d. Describe	how injur	y occurred	d		
2	eath. or: A	cati	2 Accident investig	ation				М		′es 2 🗆 l							
<u> </u>	or Ar after d Direct in by	Certification:	4 Homicide determi	ned 289. Pla	ace of Injury ilding, etc.	y - At ho (Specify	me, farm, str	eet, factory	, office		2	8f. Location (City or To	Street and wn, State,	d Number)	or Rura	l Route Num	DB/.
-	spital ours ours filled		29a. Certifier 1 Certifyin	g Physicien: To 1	the best of	my knov	wledge, death	occurred	at the tim	e, date an	d place, a	and due to the	cause(s)	and mann	ner as st	ated	
:	to the hospitel of Attending Priysicien: The law within 24 thereis lett death within 24 the Funeral Director. After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical to one)	Examiner: On the	e basis of e anner state	xaminati	ion and/or inv	vestigation	in my op	inion, deal	th occurre	ed at the time.	date and	place, an	d due to	the cause(s)	
i	To t	Σ	29b. Signature and title of certifier					290	. License	number			29d. Dat	e signed (Month,	Day, Year)	
1	0		Meh	me	\sim	1-5	D		<u>.</u>	241	020	>	7	11.	7/	06	
	(3)		30. Name and address of person	who completed ca	use of dea	th (Item	23a) (Type,	Print)	00		1 1	. 7	2 1		1.0	۸ .)
	Sta	te	31. Date filed (Month, Day, Year)	100 L	. Registrar	's Signat	146 ure	0	OL D	Yauc	74	e 16	amp	10	10	NC WO	2014
	Registr		uu 1 0 oo		•	L	for.	10								,	

		-	For State Registrar	State of M	Maryland /	,	artment of H rtificate of		and Men	tal Hygie	201	16	24268
8_ %	Discourse		1. Decedent's Name (First, Midd	lle, Last)						ate of Death	Day	Year	3. Time of Death
E	Physici /Medic	al -	Thomas D							luly		006	5:30A M
	Examin	er	4a. Facility Name (If not institution				4b. City, Town, o				4c. County		
Alla			ASbury Mo 5. Social Security Number	ethodist Vi	Llage Age (In yrs. last	birthday)	If Under 1 Year		ersburg	ate of Birth		Mont 9. Birtho	gomery lace (State or Foreign
	Funeral Director		578-07-4875	1 X M 2□ F	89	Yrs.	Months Days	Hours	Min. /	Month, Day, Ye		Coun	sh., DC
e.			Usual Residence of Decedent						1112	و ک ما	±2±/		
	how	_	10a. State 10b. Count	у	10c. City, To	own or Lo	cation					1	0d. Inside City Limits 1X Yes 2 □ No
	8a-1	Directo		ntgomery				Gaithe	ersburg				
	d within 72 hours after death with the Maryland Jiene. I than "natural", or Itema 23a or 28a-f show It e Medical Examiner must be notified at	D	10e. Street and Number	D 11 A			10f. Zip Code	26	0077	10g.	Citizen of W		
	s 23g	Funeral	11. Marital Status	Russell Ave		13	Was Decedent of H		0877	Yes or No-			States an Indian.
	ter d	Fun	1 Never Married 2 Ma	Armed Force	s?		Was Decedent of H If Yes, specify Cub			n, etc.)		, White,	
036	urs al	Ď	3 XWidowed 4 ☐ Divorce	If Yas, Giva			1 ☐ Yes 2X No	Specity:			Specify:		erican
Ò	72 ho	Completed	15. Decede	nt's Education est grade completed)	14	6a. Dece	dent's Usual Occup	oation	t of working	161	o. Kind of Bu	siness/Ind	dustry
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and	be fi	Be	17. Father's Name (First, Middle	ames Dyson				To. Mothe	ars Iname (Fir	st, Middle, Mai	Hunt	3)	
Maryland 21215-0036	2 should be and Mental Is marked o	2	19a. Informant's Name/Relation		1	19b Mailir	ng Address (Street	and Numbe	ar or Rural Ro	<i>-</i>		State Zin	Code)
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ē,	t Health tem 27 other tr		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of portatory or other plan	ark	Date		c. Location - 0		wn, State
Baltimore,	Pages nent of h ant; if its ary or o'		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (National		7/19/2	2006	Laur	e1, 1	MD
ij	교본관금 .	1	21. Signature of Funeral Service			22	2. Name and Addre	ss of Facility	y Ste	wart F	1-37	1,000	
m	Depa Depa Impo sny is		John 1	. Stewart	111		41	001 Be	enning	Rd., N	E Was	h.,	DC 20019
etc.			23a. Part 1 Enter the disease, of shock or heart failure. Lis	or complications that caust only one cause on each	sed the death. D	o not ent	er the mode of dyi	ng, such as	cardiac or res	piratory arrest			Approximate Interval Between
	Physician		Immediate Gause (Final disease or condition	Adle	elty	fa	elecre	to.	Dur	eve		C	Inset and Death
14.	/Medical Examiner		resulting in death)	Due to (or	as a consequent	ce of):	elecre	/		7			
1	Examine	_	Sequentially list conditions,	b	cour	ne	Id.		Wir	cea			
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ Due to (6)	as a consequen	Ce Oi):							
•	ate be executed hysician and the burial-transit	xan	that initiated events resulting in death) Last	C. Due to (or	as a consequen	ce of):							
8760,	siciar siciar a buria												
89	g physias the	Physician/Medical											
Вох	eath certific attending p I for use as 1	N/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	me of pregnancy 2 Eetal dea		∃Ectopic pregnanc	v			23d. Date		*
	The law requires that the death certific thas been signed by the attending page 2 should be detached for use as:	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		t at time of death		Other (specify)				Mon	ith	Day Year
P.O	that the dended by the a	Phy	9 Unknown			in the second		and a Book to	- 1	00a Did tabaa		ibto to th	e cause of death?
S,	res th	b b	Part II, Other significant condit	y arle	LLY &			ven in Panti.		1 ☐ Yes	/		ably 4 □Unknown
Records,	w requir been si should	Completed	Chrone	2 Files	LPu	11	alex	,	- 1				
3ec	e law has t	Id II		·	D.		-CCI	, ,		24a. Was an autopsy performed	/ D	rior to cor eath?	psy findings available inpletion of cause of
a			Hyperter	rsion.	race	co,	rake	2		1 Yes 2 ₺	No 1	Yes	2 No
Vital	Physician: This certificate all director, p	o Be	25. Was ase referred to medic examiner? 1 Yes 2 No	Hospital:	atient 2 ER	Outpation	ot all DOA Ott		of Death (Ch	5 ☐ Residenc		- /Casa.f	4
of		-	27. Many fer of Death	28a. Date of	njury 28	b. Time o				Describe how			7
ion	Attending I or death. actor: After by the funer	ation	1 ☑ Natural 5 ☐ Pend 2 ☐ Accident inves	ling (Month, tigation	Day Year)	Injury		rk/]Yes 2∐î	No				
Division	or Attendi after death Diractor: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	minod 288, Place Of	Injury - At home etc. (Specify)	, farm, st	reet, factory, office			Location (Stree		or or Rura	l Route Number,
Õ	ital or A irs after rat Dirac												
	To the Hospital or At within 24 hours after or To the Funeral Diract completely filled in by	edical	(Check only 2 Medica	ring Physicien: To the be at Exeminer: On the basi	s of examination								
	To the Howithin 24 To the Factorial Complete	Med	one) 29b. Signature and title of certif	and manner	stated.		29c. Licens	se number		294	Date signed	(Month	Day, Year)
N	T N N	_	1 / A 1	onthi-	1 1.		11 1	12/1	115	/	- /-	12.	2001.
^	10		30. Name and address of perso	on who completed source	of death (Item 22	Ra) /Tunh	Print)	201	DILI	5611	Allo	1/11	9
P	0		31. Date filed (Month, Day, Yea	I BIRSCA	BACCE	- 10	W	641	THEN	1584	26,0	LU	20047
	Sta Regist	ate rar		2006 See	istrar's Signature	fre	the same						

20a. Method of Disposition Main Main Main Main Main				1 - For State Registrar	State of Ma	ryland /		rtment of H		nd Mer		giene Reg. No.	2006	24	269
Marie G. Doerr Foundation Foundation Franchistic pre-structure and number Franchistic pre-structure of based on the file Town, or locations of Based and the City, Town, or locations of Based and the City, Town, or locations of Based and the City, Town, or locations of Based and the City, Town, or locations of Based and the City, Town, or locations of Based and the City, Town, or locations of Based and the City, Town, or locations of Based and the Based and the City, Town, or locations of Based and the Based and th		Dhusia		1. Decedent's Name (First, Middle, Las	t)								Year	3. Time of	
Transpoil for year to be a second plane of the control of the cont				Marie G. Doerr								-		5:45	A ^M
Soul Security Number Soul Security Number	1			4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of	Death		4c.	County of Death	1	
State Control Contro										4 Hrs 0	Data of Bio			-1 (2)	
Use a Service of Processor Document Do					"X " M 2\ F					Min.	(Month, Da	v. Year)	Cou	intrv)	r Foreign
Bernard P. Godbold											EC. 4.	, 15	710 GEU1	gia	
Bernard P. Godbold		nyland how		10a. State 10b. County		10c. City, Tox	wn or Loc	cation							•
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Bernard P. Godbold		Itam Itam	-un-		Armed Forces?		13. V	Yes, specify Cubar	n, Mexican,	Puerto Ric	an, etc.)		Black, White	, etc.	
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Provided Provided	alti	mit.		21. Signature of Funeral Service Licen:	See										
The state of the s	0	88 = 8		Kyan M. De	raer		10	6 East Ch	nurch	Stree	et, Fr	eder			
Part Provided Part Pro				23a. Part . Enter the disease, or comp shock, or heart failure. List only	lications that caused one dause on each fin	the death. Do	not ente	er the mode of dying	, such as ca	ardiac or re	espiratory a	rrest,		Interval Bety	ween
Sequentially list conditions, farm, lagring to immediate cause, life in the drying cause given in Part I. Sequentially list conditions, farm, lagring to immediate cause, life in the drying cause given in Part I. Due to (or as a consequence of): Due to (or as a consequence of	H			tmmediate Cause (Final disease or condition	•		CIF	EPATIVE	- (D1507	rder		M	MY TE	WKS
Sequentially list conditions and address of person who completed cause in flexible properties of the process of				resulting in death)	Due to (or as a	consequence	of):								T.
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Section Control of the control of the cause of death Con	റ്	exection and and rial-tra	Еха	resulting in death) Last		consequence	of):								
FFEMALE: 28. Was decedent pregnant in the past 12 gronths? 23d. Date of delivery month to the cause of death? 23d. Date of delivery month to the past 12 gronths? 23d. Date of delivery month to the past 12 gronths? 23d. Date of delivery month Day Year 23d. Date of delivery month	126	ite be iysicie ne bui	cai		d										
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25. Was case referred to medical examiner? 1 Security Securit	o.	the e	ysic	1 ☐ Yes 2 🛣 No		time of death	5 🗌	Other (specify)					10.00	<i>5</i> u, .	
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29a. Certifier (Check only one) 29b. Signature and title of certifier (Day, Year) 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) Wayne Allgaier, MD, 610 Ninth Avenue, Brunswick, Maryland 21716 31. Date filled (Month, Day, Year) 32. Registrar's Signature	ta	an: rtifice tor, p	0						26. Place o	of Death (C			I Tes	2 LI NO	
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30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) Wayne Allgaier, MD, 610 Ninth Avenue, Brunswick, Maryland 21716 State 31. Date filled (Month, Day, Year) 32. Registrar's Signature		To the within To the Comp	M	29b. Signature and title of certifier	0.4.0			29c. License	number			29d. Date	e signed (Month	, Day, Year)	
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	*4		For Amen#19a 7/21/0 1 = Stete Registrar Per FH AACO		-		rtment				iene	16	24270
16		r.	Decedent's Name (First, Middle, La		LVIII.					2. Date of Dear		Vans	3. Time of Death
	Physicia /Medic		IREN	e L	VE	TON	/			JULY	12 20	Year 206	0625AM
	Examin		4a. Facility Name (If not institution, give						ation of Death		4c. County of		
			Sunrise Assiste		je (In yrs. las	t hirthday)	If Under 1		na Par) Under 24 Hrs.	8. Date of Birth			rundel
*	Funeral Director		101-24-7559	1 M 2 M F	104	Yrs.			lours Min.	Oct. 17	, Year)	Coun	place (State or Foreign htry) MA
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Loc	cation					1	0d. Inside City Limits
	hours after death with the Maryland tural; or Items 23a or 28a-f show at Exacutrational be notified at	tor	MD Anne A	Arundel			Seve	erna 1	Park				1 ∏Yes 2 XNo
	or 28s	Director	10e. Street and Number				10f. Zip C			1	0g. Citizen of W		ıtry?
	ath w	<u>e</u>	43 McKinsey Road	-		1 42 1			146			JSA	
	after dea or Items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀)	13. V	Yas Decede Yes, specifi	nt of Hispa y Cuban, N	nic Origin? (S lexican, Puert	pecify Yes or No- o Rican, etc.)		k, White,	ean Indian, etc.
21215-0036	i within 72 hours after der liene, rthan "natural", or Itema Ite Medical Exaculation	þ	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2	No S	pecify:		Specify:	W	Mite
5-0	72 hours 'natural', dical Exa	eted	15. Decedent's E (Specify only highest gr.	ducation ade completed)		(Give	lent's Usual kind of work	done durin	n ng most of wor	king	16b. Kind of Bu	siness/Ind	dustry
121	within ene. then.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		00 NOT use H omem a	_ ′			Hom	ne	
	it ty	au l	17. Father's Name (First, Middle, Last)				18.	Molher's Nan	ne (First, Middle, i	Maiden Sumami	в)	
/lar		To B	Antonio Silva		_				Maria	G. Ropoz	za		
Maryland	d 2 should th and Mer 7 is marke traumatic	1	19a. Informant's Name/Relationship (Type, Print)						ral Route Number			Code)
	Heali Heali Fm 2		Snirley D. COOK	Daugnter	20b. Plac		sition (Name natory or oth		1	napolis,	MD 214 20c. Location -	-	own. State
Baltimore,			1 ☐ Buriai 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special				natory or oth emato:		July	7 14, 2006	Baltim	-	
alti-	当世世世		21 Signature of Juneral Se		rice								eral Home
ä	Dep Imp	1	ametro)	Blo	nu	49	5 GOV.	. Kit	cure H	vy, Sever	rna Park	. Full	21146
			23. Enter the disease, or con shock, or heart failure. List only	ofe cause on each li	ine.								Approximate Interval Between Onset and Death
Pen	Priysician	1	Immedia 5 Cause (Final disease / r condition resulting in death)				OCAF	2D1/4	LIN	FARCTI	ion	_2	DMINUTES
	/Medical Examiner	(/ [Due to (or as	a consequer	nce of):	AR	'ir=	V O	150AS	0 1	7 W	LOADS
		Je.	Securitary list conditions if any, leading to immediate cause. Enter Underlying	b. Due to (or as			111	100 /6	. 7 0			~ /	
	be executed sicien and burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c									
760,	be exe icien a burial-	cal Ex	resulting in death) Last	Due to (or as	a conseque	nce of):							
687	# % 6			_ d.									
Box (eath certificat attending phy I for use as the	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pre	200001			23d. Date	of delive	эгу
O. B	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant a 9☐ Unknown			Other (spec				Mon	th	Day Year
Δ.	that the		Part II. Other significant conditions	contributing to death t	out not resulti	ing in the ur	nderlying cau	use given in	Part I.	23e. Did to	bacco use confi	bute to th	he cause of death?
Records,	quires an sign uld be	ed by	CEREBROV	ASCULI	AR /	100	De	WT		1 □ Y	es 2 No	3 🗌 Prob	pably 4 Unknown
oce	law requir as been si 2 should	Completed	HY PERTEI	NSION	,					24a. Was a			psy findings available mpletion of cause of
œ.		Com								perfori	med2 d	leath?	
Vital	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor		th (Check only on			A50 c -050
of	Phys this ral di	. To	1 Yes No	28a. Date of Inju	ent 2 EF	R/Outpatien 8b. Time of			4 Nursing H	ome 5 Reside			WING
lon	Attending Indeath.	atlon	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	м	c. Injury at Work? 1 Yes	2 N o		1,		FACILITY
Division	or Attendate after death Director: A	Certification;	3 Suicide 6 Could not to determined	286. Place of in	jury - At hom tc. (Specify)	e, farm, stre	eet, factory,	office		28f. Location (Si City or Town	treet and Numbe n, State)	or Rura	Il Route Number,
_	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical Ce	29a. Certifier 1 Certifying P	hysician: To the best miner: On the basis o	of my knowle	edge, death	occurred at	t the time, o	date and place	, and due to the c	ause(s) and mar	nner as s	tated.
	ths H hin 24 the F mplete	Medi	one) 29b. Signature and title of Sertifier	and manner st	ated.	/		License nu			9d Date signed		
	To cor		Mukan	1 Aix	ful	mi	1	04	6366	/ '	July 13	, 2	006
			30. Name and address of person who	completed cause of	death (Item 2	За) (Туре,	Print)	Ilver	Malh : 1	1	110 11	00	1100
	Sta	ate.	31. Date filed (Month, Day, Year)	324Regist	rar's Signatur	re	KHNS	MEH	WAY 1	Judesvi	uc IVI	11	1100
Y	Regist		_	006	. K	A.	2000			•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Dakin Я Fleming 11:12 Jean 07 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 1 F Yrs. 014-20-4931 10/18/1926 Massachusetts Director 79 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County *how : if Item 27 is marked other than "natursi", or Items 23a or 28a-f shov or other traumatic event, I<u>t a Madical Examinal must be notified at</u> 1 ☐ Yes 2 ☐ No Salisbury Funeral Directo Wicomico Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 939 Gateway Street Apt. 316 death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I 9 Alice Madigan Edward Fleming . Pages 1 and 2 should by iment of Heelth and Menta tent: If Item 27 is marked 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) General Delivery San Francisco, CA 94142 Ann Brabant/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State sertment (sortant: If Salisbury Crematory Salisbury, MD unknown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Holloway Funeral Home Professional Association 21. Signature of Funeral Service Cic. Deper mpor nny r 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART Failure Physician 2 YEARS /Medical Due to (or as a consequence of): Examiner AJCVD 5 years Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an rector, page 2 s autopsy performed? 2**7** No 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Symposidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how intury occurred 28b. Time of Certification: 27. Manger of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide

P.O. Box 68760. of Vital Records, the Hospital or Attending Physician: Division s after dea. To the Hospital o within 24 hours att To the Funeral Di completely filled in

who was D051359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. DIVISION ST. SAUSBURY MD 21804 1415 NATEJAN USHA

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

July 19, 2006

			1 - For Stete Registrar	State of Ma	aryland			nt of H Ite of L		id Me	ntal Hy	giene Reg. No	401	16	24	272
/II	Physicia	an	Decedent's Name (First, Middle, Last	st)						1	. Date of De	eath Da	у ,	Yeer		of Death
	/Medic	al	Carl Robert Engl: 4a. Facility Name (If not institution, give				4b Cit	Tour or	Location of D	_	uly 1		006 County of	Dogth	8:35	Ам
	Examin	er	Prince Georges Ho					ver1v		76atri					orges	
	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. la:	st birthday)		er 1 Year	If Under 24	Hrs. 8	Date of Bi	rth				or Foreign
	Director		233-60-7064	© M 2□F	55	Yrs.	IVIOITAT	Duys	110013	A	pril	10,	1951	WV	,	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation								10d. Inside	City Limits
	Mary B-f sh	tor	Maryland Prince	Georges	Kett	ering									1 💢 Y€	s 2 No
	or 28	Director	10e. Street and Number					ip Code					izen of Wh	nat Cou	ntry?	
	23a	rail	12633 Darlenen St			140.1		774	0.1.1	2 (0	N	USA		A		
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 le marked other then "naturel", or Iteme 23a or 28a-f show any fujury or other treumatic event, If a Medical Exact in a finite be notified at ODGs.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2X N If Yes, Give Year or Dates:				edent of Hi ecify Cuba	spanic Origin n, Mexican, F Specify:	7 (Speci Puerto Ri	y Yes or No can, etc.)	0-		, White,	can Indian, etc. ack	
212-003a	72 hou		15. Decedent's Ec (Specify only highest gra			16a. Deced	dent's Us	ual Occupa	ation	t working		16b. K	ind of Bus			
Ž	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)				furing most of	working		77	·			
7	iled w Hygier ther th		17. Father's Name (First, Middle, Last)	5+		Regio	naı	Manag	18. Mother's	Name (/	First Middle		izon)		
ana	ld be l ental I ked o	To Be	Harry Burger						Elsie			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,		
ary	and Memory	_	19a. fnformant's Name/Relationship	Type, Print)		19b. Mailin	g Addre	ss (Street a	and Number			er, City	or Town, S	tate, Zip	Code)	
Σ.	and 2 ealth m 27 I		Tashika English/	Daughter	1001 51				ve Cou							
ore	iges 1 it of H if Ite		20a. Method of Disposition 1 XBuriat 2 Cremation 3 C		cer	ce of Dispo netery, cren Blu	natory of	other plac		Dat			ocation - C		own, State	
Saitimor	artmer artmer ortant Injury		4 Donation 5 Other (Specifical Service Licenter)		Mem	orial 22			0 /		2006		kley,		al Ho	me
n	Dep Imp any		> & Phys			,			polis						ar no	
78.0 78.0	i ing		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death.	Do not ent	er the m	ode of dyin	g, such as ca	rdiac or r	espiratory a	ırrest,			Approxim	etween
2	Physician		fmmediate Cause (Final disease or condition resulting in death)	a. Fatal C			hyth	mia							Onset an	d Death
	/Medical Examiner		rosaliang in docum,	Due to (or as	a conseque	ence of):										
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09/80	ficate p phys	edicai	•	d												
XOD	at the death certifi I by the attending I	Physician/M	fF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth 4□Pregnant at	2 Fetal d	leath 3[Ectopic Other (pregnancy					23d. Date Mont		ery Day	Year
j	the de	hysic	1 Yes 2 No 9 Unknown	9☐ Unknown	1110 01 000	5	001101	specify)								
S,	as th	by P	Part II. Other significant conditions of	ontributing to death bu	ut not result	ting in the u	nderlying	cause give	en in Part I.						he cause o	
ecord	w require been sign should b	ted	Diabetes								10	Yes 2	No 3	Prot	oably 4 [Unknown
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VITAI H	sician: The law certificete has b irector, page 2 s	e Co	25. Was case referred to medical						OC Bines of	Death //	1 Yes	2 X No	1 [Yes	2□ No	
	Physician: this certific ral director,	To B	examiner?	Hospital: 1 Inpatie	nt 2 XE	R/Outpatien	t 3 🗆 l	Othe	26. Place of er: 4 🗌 Nursi		5 ☐ Resi		6 ☐Other	(Specil	(v)	
0	ding Phys h. After this funeral di		27. Manner of Death 1 ♣ Natural 5 ☐ Pending	28a. Date of fnjur (Month, Day	ry Year) 2	28b. Time of Injury		28c. Injury Work			d. Describe					
<u>o</u>	Attending r death. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be				М	10	Yes 2 □No			-				
DIVISION	2022	Certification:	4 Homicide determined	28e. Pface of Injubulding, etc	ury - At norr c. <i>(Specify)</i>	16, farm, str	eet, facte	ory, office		281	Location (City or To	Street ar wn, State	id Number 9)	or Hura	ai Houte Nu	imber,
	전 수 <u>구</u> 등	edical (29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysicien: To the best oniner: On the basis of and manner sta	examination	ledge, death on and/or in	occurre vestigation	d at the tim on, in my op	ne, date and pointion, death	occurred	d due to the at the time,	cause(s date and) and manr d place, an	ner as s id due ti	tated. o the cause	o(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	011				9c. License				29d. Da	te signed ((Month,	Day, Year	
			1 (a	CX			P	10	158	1		7	112	10	6	
			30. Name and address of person who	/ /					MD 00	177/						
18	Sta	te	Carl Johnson, MD 31. Date filed (Month, Day, Year)	1221 Merc			ne 1	argo,	אט עני	1//4						
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		•	For State Registrar	State of Ma	ırylan			nt of H te of L				giene Reg. No	2000	24273
			1. Decedent's Name (First, Middle, Last)							2. Date of De	ath Da	v Year	3. Time of Death
	Physici /Medic		Donna	R	ae		E	aton					2006	20:50 M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City	, Town, or	Location	of Death		40	. County of Death	1
			MEMORIAL HOSPITA					MBERI		0411		_	ALLEGANY	
	Funeral		5. Social Security Number 6. Se	TM SELE	, ,	last birthday) Yrs.	Months	or 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ıy, Year)	Col	place (State or Foreign intry)
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	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y. Town or Lo	cation							10d. Inside City Limits
	daryl	ō	MD Allega	nv		Cum	berl	and						1√ Yes 2 No
	the !	Director	10e. Street and Number					ip Code				10g. Ci	tizen of What Cor	intry?
	with Se or	٥	538 Maryland	Avenue				21	1502				USA	
	ns 23	era	11. Marital Status	12. Was Decedent E	ver in U.	.S. 13. \	Nas Dec	edent of Hi	spanic Ori	igin? (Spe	cify Yes or No Rican, etc.))-	14. Race - Amer	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "naturel", or items 23a or 28a-f ehow surnatic event, the Madical Examinar must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 XN If Yes, Give Year or Dates:	lo				n, Mexicar Specify:		Rican, etc.)		Black, White	.etc. hite
ĕ	2 hot		15. Decedent's Edu	cation		16a. Deced	lent's Us	ual Occupa	ation	e of worki		16b. K	(ind of Business/I	
7	7 nin 7.	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5-	+1	life. L	DO NOT	ork done d use retired	<i>unng</i> mos)	at or work!	ng			
2	d with	E O	10	- Combge (1 40) 5	.,	Di	etar	°y					Nursin	g Home
ğ	othe	ادہ	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle	, Maider	n Sumame)	
<u>a</u>	ould be filed v Mental Hygie wrked other t	To B	Raymond	Patrick	Br	ridges			Edi	.th	Eliz	zabe	th P	erry
an	should and Meniarke		19a. Informant's Name/Relationship (T)	(pe, Print)		19b. Mailir	ng Addre	ss (Street a	and Numb	er or Rura	I Route Numb	er, City	or Town, State, Z	ip Code)
	is 1 and 2 should of Health and Men item 27 is marke other treumatic		Heather Hite / da	ughter	,				Aven					nd 21502
altimore,	of He of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ I	Removal from State	20b. P	Place of Dispo cometery, cren	sition (Natory or	ame of other place	ө)		ate	20c. L	ocation - City or I	own, State
Ĕ	Pages nent of ant: If it		4 □Donation 5 □Other (Specify,		Cun						/2006	Cu	mberland	, MD
a	permit. Page Depertment of Important: If any injury or ance.		21. Signature of Funeral Service Licens	900		22	. Name	and Addres	s of Facili	ty Ad	ams Far	nily	Funeral	Home, P.A.
0	8988		1 Locust C. C	Home		1	104 I	ecati	ur St	reet	, Cumbe	erla	nd, MD	2 1 502
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause on each lin	the deat	h. Do not ent	er the mo	ode of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Cardia	ac Ar	rrest								Onset and Death
	/Medical		resulting in death)	Due to (or as a										
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Ö,	be executed sicien and burial-transit	Ä	resulting in death) Last	Due to (or as a	a conseq	uence ol):								
8760	cate b	dical	•	d										
9	leath certific ettending pl	Med	IF FEMALE:		10101									
Box	ath ce	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 🗌 Feta	ildeath 3□		pregnancy					23d. Date of deli	very Day Year
	the el	sici	1 Yes 2 No	4□Pregnant at 9□ Unknown	time of d	leath 5 [Other (specify)						
<u>а</u>	that the de ed by the detached	Physician/Me	Part II. Other significent conditions co	ntobuting to doath bu	it not roc	ulting in the u	ndorhung		on in Part		23e Did	ohacco	use contribute to	the cause of death?
Division of Vital Records,	Attending Physicien: The law requires that the death certificate be executed in death. •ctor: After this certificate has been signed by the ettending physicien and by the tuneral director, page 2 should be detached for use as the burial-transit	۾	Renal Failure	This time to dead to	20100103		ndonying		J. T. T. G. C. C.			Yes 2		obably 4 ∐Unknown
ဝင္ပ	has be	Completed									24a. Was	DSV	24b. Were au	opsy findings available ompletion of cause of
<u> </u>	ysicien: The lis certificete hadirector, page	် ပ									1 ☐ Yes	2 No	o death?	2 □ No
≅	icien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth	200		(Check only			
=	Physic this c	၉	1 Tes 2 TNO	Hospital: 1 ☐ Inpatie		ER/Outpatien			4 114				6 ☐Other (Spec	ify)
ח	Ing P	Ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	м	28c. Injury Work			28d. Describe	now inju	iry occurred	
Sio	death death ctor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	and Blood of Lor	44.6				Yes 2□		79f Location /	Ctenat a	ad Numbos os Bu	ral Route Number,
<u>></u>	F 0 F	Certification:	4 Homicide determined	28e. Place of Injubulding, etc	: (Specif	by)	eet, lacto	жу, опісе		,	City or To	wn, Stat	e)	a note valiber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical (29a. Certifier 1 Cartifying Phy (Check only one)	rsician: To the best of inar: On the basis of and manner sta	examina	owledge, death ation and/or in	h occurre vestigation	d at the tim on, in my op	ne, date ar pinion, dea	nd place, a ath occurr	and due to the ed at the time,	cause(s date an	s) and manner as nd place, and due	stated. to the cause(s)
	Nithin Fo the	Me	29b. Signature and title of certifier	_	\		2	9c. License	e number			29d. Da	ate signed (Monti	. Day, Year)
	. , , , ,		1 Daniel	Celh	- '	m	5	Т	05441	1			July 20	, 2006
	3		30. Name and address of person who co	ompleted cause of de	eath (Iter	п 23а) (Туре,	Print)		<u> </u>	+				
	MRS		CALKINS, BEVERLY	M., M.D.,	500) МЕМОБ	RIAL	AVENU	JE, S	UITE	105,	UMBI	ERLAND,	MD 21502
	Sta Registi		31. Date liled (Month, Day, Year)	32 Registra	ar's Signa	ature do	ا داله	,						
	negist	1.1	AAL TEOD	March of the co		1075	1							

			1- State of Mar Registrar AACO HEALTH DEPT. ON 17/17	_	artment of H rtificate of I		Mental Hygid	ene: UUto	24214
1 5	Physici	20	Decedent's Name (First, Middle, Last)	700			2. Date of Death Month	Day Year	3. Time of Death
75-	/Medí		Selim Eren				July	12, 2006	16:01 ^M
	Examir	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Dea	ath	4c. County of Dea	th
	uneral		Harbor Hospital Center 5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday)	If Under 1 Year	altimore If Under 24 Hr	S. A Date of Birth	9 Bir	thplace (State or Foreign
	rector		212-84-9172 ^{1X M 2□ F} 38 3		Months Days	Hours Mir		1967	NY
pu	R rest		Usual Residence of Decedent	t Oc. City, Town or Lo	- ation				
Aaryia	sho	ō	MD Anne Arundel	oc. Ony, rown or Ec	Miller	etri 11a			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
death with the Maryland	28a-	Director	10e. Street and Number		10f. Zip Code	SVIIIC	100	g. Citizen of What C	
h with	23a ol		402 Phenita Point Drive		2	1108			JSA
	ams i	Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of Hi	ispanic Origin? (Specify Yes or No- into Rican, etc.)	14. Race - Ame Black, Whi	encan Indian,
36 s afte	or II	by Fu	1 Never Married 2 Married 1			Specify:	,		Vhite
Maryland 21215-0036 d 2 should be filed within 72 hours after th and Mental Hygiene.	atural', or Itams 23a or 28a-f show cal Executor court be notified at		3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education	16a, Dece	dent's Usual Occupa	ation	16	6b. Kind of Business	
VIZIS within 72 ene.	든행	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of we	orking	DD. 14110 OF DUSINGS	moustry
d 21 filed wit Hygiene	other tha	Com	4		ntreprene	ur		Self-Emp	oloyed
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Man 142 st 11th an	P ==		Hal Eren, Esq./Brother				Rural Route Number, (Lite 1005,		
Saltimore, bermit. Pages 1 ar Department of Hea	Item 2 other		20a. Method of Disposition	20b. Place of Dispo			Date 20	Oc. Location - City or	
Pages			1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	MD Nat'l			Tuly 15, 2006	Laurel, M	D
Baltim permit. Pag Department	Import any inj once.		21. Signature Funeral Service Licensee	, 22 E	. Name and Addres	SONS .		na Park F	uneral Home
<u> </u>	드통데		ames to lason	4	95 GOV. I	Ritchie	Hwy. Sever	na Park	MD 21146
			23t Part. Enter the disease, or complications that caused the shock for heart failure. List only one cause on each line.	e death. Do not ent	er the mode of dying	g, such as cardia	ac or respiratory arres	it,	Approximate Interval Between Onset and Death
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	miner			onsequence of):	J Faile	190			
The state of the s		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):	100(10				
ecords, P.O. BOX 68/60, law requires that the death certificate be executed	ng physician and as the burial-transit	Examiner	that initiated events .						
Š, Š	ician burial	a E	Due to (or as a c	consequence of):				. 1	
58/50 ficate be e	phys s the	edicai	d	ASS					
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dead u	e ette	Physician/M	in the past 12 months?]Ectopic pregnancy] Other (s <i>pecify)</i>			Month	Day Year
T a the C	d by the	Phys	9 □Unknown 9□Unknown					<u> </u>	
res th	signed bed	þ	Part II. Other significant conditions contributing to death but I	not resulting in the ur Sean e	nderlying cause give	en in Part I.			the cause of death?
ecords,	peen	eted	- 279KONE (1900)	Jane			1 Tes	2 No 3 □ Pr	obably 4 Unknown
	has l ge 2 s	Completed					24a. Was an autopsy performe	prior to	itopsy findings available completion of cause of
Vital licien: Th	ificate or, pa	e Co	25. Was case referred to medical				1 Yes 25		2 No
Valcie V	s cert direct	O B	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 X ER/Outpatien	t 3 DOA Othe		eath (Check only one) Home 5 🗌 Residence	co 6 DOthor (Coo	aiful
TO TO BE	ter thi	n; T	27. Manner of Death 28a. Date of Injury	28b, Time of	28c. Injury Work	at	28d. Describe how		Sily)
SIOI endir eath.	or: Af	catic	2 Accident investigation			res 2 □No			
UIVISION For Attending after death.	Direct in by 1	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (- At home, farm, stre (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	iral Route Number,
UIVISION OT VITAL RECORDS, P.O. To the Hospitel or Attending Physicien: The law requires that the de within 24 hours after death.	neral , filled	ai Ce	29a. Certifier 1 Cartifying Physician: To the best of r	my knowledge, death	occurred at the tim	e, date and plac	e, and due to the caus	se(s) and manner as	stated.
he Hc in 24 l	he Fu	edical	one) Relimedical Examiner: On the basis of examiner states	camination and/or inv	estigation, in my op	oinion, death occ	urred at the time, date	and place, and due	to the cause(s)
To t withi	COM	Σ	29b. Signature and tipe of entities	·	29c. License			. Date signed (Monti	
			1 ASWA	MD	1 .0	2041	U	7/14/0	26
			30. Name and address of person who come d cause of deal SRIDITAR. ATLURI, 8109	th (Item 23a) (Type, I	Print)	Palace	dema MI	2112 2	
-	_	_	SISINITATE (TILLOTT) BIOL	- incolle 11	A. Mary	1 uz		0.110	

Registrar

DHMH 17 Rev 1/2001

onth, Day, Year)

JUL 17 2006

32 degistrar's Signature

			State of Manyland / Den	artment of Health and Mental Hygiene	
		•	FOR	rtificate of Death Reg. No. 0	06 24275
			Decedent's Name (First, Middle, Last)	2. Date of Death Month Day	3. Time of Death
П	Physicia /Medic		MARY ELIZABETH GILROY		06 10:35P M
	Examin		4a. Fecility Name (If not institution, give street and number)		ty of Death
			8310 GILROY ROAD	NANJEMOY If Under 1 Year If Under 24 Hrs. 8, Date of Birth	CHARLES
	Funeral		5. Social Security Number 6. Sex 1 ☐ M 2 ☒ F 7. Age (In yrs. last birthday 7. Age (In yrs. last	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. MAR . 14 , 1949	9. Birthplace (State or Foreign Country) NORTH CAROLIN
	Director	1	Usual Residence of Decedent	MAK.14/1747	
	ylanc how		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	sa-f s	cto	MARYLAND CHARLES N	ANJEMOY	
	or 26	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of	f What Country?
	a 23e	eral	8310 GILROY ROAD 11 Marital Status 12. Was Decedent Ever in U.S. 13	20646 U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-	Ace - American Indian,
.	fter d	Fun	1 ☐ Never Married 2 1 ☐ Yes 2 ☐ No	- 1747	ack, White, etc.
980	al', o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes XIXNo Specify: Speci	"" WHITE
2-0	be filed within 72 hours after death with the Maryland nta! Hygiene. So other than "natural", or Itema 23a or 28a-f show event, the Modical Examiner mat be notified at	Completed by Funeral	(Specify only highest grade completed) (Giv	kind of work done during most of working	Business/Industry
121	within	du l	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) GET ANALYST DEPT	GOVERNMENT
d 2	filed Hygie Sther	ပိ	12 4 BUD 17. Father's Name (First, Middle, Last)	GET ANALYST DEPT 18. Mother's Name (First, Middle, Maiden Suma	OT IALLA T
an	Mental Mental arked o	To Be	GLENWOOD EARL BAZEMORE	FRANCES ANN CASTE	I.I.O
Maryland 21215-0036	2 should be and Mental is marked (sumatic ev	_	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ng Address (Street and Number or Rural Route Number, City or Town	n, State, Zip Code)
	5 를 2 3			O GILROY ROAD, NANJEMOY, MAR sition (Name of Date 20c. Location	YLAND 20646 n - City or Town, State
Baltimore,	Pages 1 au nent of Hea int: if item iry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place)	1- City of Town, State
Ë	t. Partimentant:			CEMETERY 7/25/06 NANJE:	MOY, MARYLAND
Ba	permit. Pages Department of I Important: if it any injury or o		m/ + //	RAYMOND FUNERAL SERVICE, P	. A .
		-	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	of Cours	Onset and Death
	/Medical	.	resulting in death) Due to (or as a consequence of):	N	
	Examiner	_	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	L aturno	
1/	led nsit	nine	cause. Enter Underlying Cause (Disease or injury		
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760,	0 8 0	cal	d		
89	rtifica ng ph	Med	IF FEMALE:		
Вох	ath ce trendi	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	T-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	ate of delivery Month Day Year
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Δ.	requires that the death certifical een signed by the attending ph hould be detached for use as th	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use con	ntribute to the cause of death?
rds	v requires been sign should be			1 ☐ Yes 2 ☐ No	3 Probably 4 Nonknown
Vital Records,	~ 0 0	Completed		autopsy	. Were autopsy findings available prior to completion of cause of
<u> </u>	The law ate has b page 2 sl	Соп		perfórmed? 1 ☐ Yes 2 □ No	death? 1 Yes 2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only one) Other: 4 Debugging Home 5 Providence 6 DC	wt (2) (1)
of	his his	: To	27 Manner of Death 28a. Date of Injury 28b. Time	TI 3 DOA 4 Not siting Hottle 3 Zamesidence 0 00	
lon	Attending in death.	atlor	1 X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 Yes 2 No	
Division	ii or Attending P after death. I Director: After t d in by the funera	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	reet, factory, office 28f. Location (Street and Nun City or Town, State)	nber or Rural Route Number,
۵	Hospital or A 24 hours after Funeral Directely filled in by				
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in b	edical	29a. Certifier 15 Certifying Physician: To the best of my knowledge, de. (Check only one) 2 Medical Exeminer: On the basis of examination and/or and manner stated.	th occurred at the time, date and place, and due to the cause(s) and nivestigation, in my opinion, death occurred at the time, date and place	anner as stated. a, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie	29c. License number 29d. Date sign	ned (Month, Day, Year)
			Just Wall im	1 0006 29 111	20/06
	h		30. Name and address of person who completed cause of death (Item 23a) (Typ	MD. WALDORG. MD.	20603
	, Sta	ate	31. Date filed (Month, Day, Year) Registrar's Signature	. M. I	
	Regist	rar	AUG 0 2 2006 Sleven & Ap		

State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month JULY 2006 Physician 16 9:30 A M GREY MARY ANN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S 9604 CEDAR CREST WAY SPRINGDALE | If Under 1 Year | ff Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | APRIL 2 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F Yrs. 579-44-0575 APRIL NORTH CAROLINA **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits ir then "natural", or iteme 23s or 28s-f ehow The Medical Examiner must be notified at SPRINGDALE 1 Yes 2 □ No MD PRINCE GEORGE'S Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 U.S.A. 9604 CEDAR CREST WAY Pages 1 and 2 should be filed within 72 hours after deeth vent of Heelth and Mental Hygiene. Int: If Item 27 Ie marked other then "natural", or Iteme 23 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 X Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Efementary/Secondary (0-12) Colfege (1-4or 5+) GOVERNMENT LAB TECHNICIAN 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ESSIE MOSES LUTHER HAGOOD ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 WENDY E. WASHINGTON/DAUGHTER 9604 CEDAR CREST WAY SPRINGDALE, MARYLAND other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if eny injury or once. 7/27/2006 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a coheaquence of): Examiner for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1□Live birth 2□Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) sete hes been signed by the a page 2 should be detached in 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 Yes 21 No After this certific funeral director, 25. Was case referred to medical 26. Pface of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitaf: Certification; To 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 X Natural 5 Pending 1 Tes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the funeral completely filled in the funeral completely f investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the ! 29b. Signature and the of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0037529 JULY 17, 2006 ario completed cause of death (Item 23a) (Type, Print) RONALD WHEELER M.D. 1221 MERCANTILE LANE LARGO, MARYLAND 20774 31. Date fifed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

JUL 1 9 2006

3	7	1	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 4 2 7 7
	Physicia		1. Decedent's Name (First, Middle, Last) MARY GONZALES 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year 1. 1. 05 p. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	LXumm	Ŭ.	Northwest Hospital Center Randallstown Baltimore
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 XF 81 7. Age (In yrs. last birthday) 1 M Nonths 1 Days 1 Months 1 Days 1 Min. 8. Date of Birth (Month, Day, Year) Mar 23, 1925 9. Birthplace (State or Foreign Country) Maryland
	and W		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Maryl feb	Į.	Maryland Howard Ellicott City
	r 28a	Funeral Director	Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	th with	a D	5320 Dorsey Hall Drive 21042 USA
	eme erms	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Drigin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
36	72 hours after deeth with the Maryland Insturati, or itema 23e or 28e-f ehow disal Examinat must be notified at	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give Year or Dates: 1 □ Yes 2 ☒ No Specify: Yes Provided Specify: White
9	2 hour	edi	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
21215-0036	- CI	ple	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)
21	be filed within 72 hours after deeth with the Marylan it all tygiene. Identifysione. Identif	Completed	1 Secretary Federal Government
	2 should be filed withir and Mental Hygiene. is marked other then aumatic event, the Me	Be	17. Father's Name (First, Middle, Last) Maurice Gregg Brownlev May Elizabeth Phelps
<u> </u>	hould d Mer marke matic	ဥ	Maurice Gregg Brownley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>⊠</u>	nd 2 s ith an 27 is r	i	Walter Gregg Meade/son 779 Whitneys Landing Rd. Crownsville, MD 21032
ē,	s 1 ar f Hea item othe	1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Ë	Page nent o int: If iry or		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 07/19/06 Beltsville, MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic es		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heef failure. List only one cause on each line. Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition
	/Medical		resulting in death) Due to (or as a consequence of):
	Examiner		Sequentially list conditions, if any leadin, to immediate b. Due to (or as a consequence of):
	ed sit	ine	if any leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury
	xecut and	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):
8760,	cate be executed physicien and the burial-transit	cal	d.
9	tificat ig phy as the	led	
Вох	requires that the death certificate be executed seen signed by the attending physicien and hould be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12,mg/nths? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy Month Day Year
о <u>.</u>	res that the de signed by the a be detached f	ysic	In the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)
Δ.	that the part of t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Records,	w requires been sign should be	Completed by	ATRIAL FIGRILLATION 14 Y DERTENSION, 10 Yes 27 No 3 Probably 4 OUNKnown
000	2 S S	plet	LITERINE CANCER, BREDST CANCER 24a. Was an autopsy findings available prior to completion of cause of
E E	The ete h	E	performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
/ita	icien: Th certificete rector, pag	Be C	25. Was case referred to medical examiner? 26. Place of Death (Check only one)
Division of Vital	this ald	2	1 Yes 2 No
uo	fe fe	tion	1 Natural 5 Pending (Month, Day Year) Injury Work?
isi	Attender death	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
Ö	ei or / s after il Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify) City or Town, State)
	To the Hospitei or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical (29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within To the compl	Me	29b. Signature setitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) Thur 1 th 2006
<u> </u>	2		36 Name and address of person who completed cause of death (Item 23a) (Type Print)
مرار •			31. Date filed (Month, Day, Year) 32. Redistrar's Signature
	St: Regist	ate rar	JUL 2 0 2006 Scene & Spelle
			The state of the s

			1 - For State Registrar Amend #23 I	State of Mar					ene 2006	24278
	N N		Hegistrar America 1/23 1 Decedent's Name (First, Middle, La.		G0 J0 04 F	4//00/191P		2. Date of Death		3. Time of Death
	Physicia		JONATH		DERM.	AN		Month /	Cith ZOO	130AM
	/Medic Examin		4a. Facility Name (If not institution, giv	.,		4b. City, Town, or I	Location of Death	0007	4c. County of Deatl	1
	Examili	eı	471 Broadwater	Road		Ar	nold		Anne A	rundel
	Funeral		5. Social Security Number 6. S	iex 7. Age (In yrs. last birthday,	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	(ear) 9. Birtl	nplace (State or Foreign untry)
	Director		220-03-5969	XIM 2□F	85 Yrs.	Months Days	riours will.	Sep. 2,	1920	MD
	p ,		Usual Residence of Decedent 10a, State 10b, County	1	0c. City, Town or L	ocation				10d. Inside City Limits
	ehov ehov nd at	5		Arundel	oo. o.t.y, 101111 of 2		Arnold			1 □Yes 2 No
	28a-1	Director	10e. Street and Number	Turder		10f. Zip Code	ALIOIG	100	g. Citizen of What Co	untry?
	a or		471 Broadwater	Poad		210	112	''		SA
	s 23	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of His		pecify Yes or No-	14. Race - Ame	
	ther d	F	1 Never Married 2 Married	Armed Forces? 1 ∑Yes 2 □ No	WWII	If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, White	
3	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	*****	1 □ Yes 2 ☑ No	Specify:		Specify:	White
Ŏ	filed within 72 hours after death with the Maryland Hygiene. other than "naturel", or Items 23e or 28e-1 ehow ent, Ira Madical Examinational be inclified at	Completed	15. Decedent's E		16a. Dece	edent's Usual Occupa e kind of work done di	tion	king 10	6b. Kind of Business/	ndustry
2	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)		9	BG & E	
7	ed wi	Con	12			Liaison				
nd	tal H do of the off	Be	17. Father's Name (First, Middle, Last				_	ne (First, Middle, Ma Grace Gej		
<u>X</u>	ould Men Parks Patic	To	Bertram Lee Boon		405 1457					Tin Codel
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or Items 23a or 28a-1 show any injury or other traumatic event, Itra Modical Examinat must be notified at ODGs.		19a. Informant's Name/Relationship (Pauline E. Germa			ing Address (S <i>treet</i> a. 1 Broadwat			City or Town, State, Z	
e,	i and Healt em 2		20a. Method of Disposition		20b. Place of Disp	osition (Name of	-	Date 2	0c. Location - City or	Town, State
סר	nt of it		1 🔀 Burial 2 ☐ Cremation 3 ☐		cemetery, cre	ematory`or other place rans Cemet	Ju]	v 13.	Crownsvill	
Baltimore,	it. Partament oilury		4 ☐ Donation 5 ☐ Other (Special Service Lice		2	22. Name and Address	s of Facility			
Ba	Depi Impo		1/homes/	Allen		Barranco &	Sons. E	P.A. Sever	rna Park F rna Park,	uneral Home
- 9			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused th						Approximate
	Dharaisian		Immediate Cause (Final				FAIL			Interval Between Onset and Death
N.	Physician /Medical		disease or condition resulting in death)	a	GESTIVE consequence of):	. I EAR	177/6	ore		10 YEARS
	Examiner		1		,					
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8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical	•	d						
9	ing p	Mec	IF FEMALE:						III recent	
Вох	eath certifu attending I	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	□Ectopic pregnancy			23d. Date of del Month	ivery Day Year
0	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□ Unknown	ne or death 5	Other (specify)		-021 M C 2		
<u> </u>	requires that the de een signed by the a hould be detached	'Ph	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ds,	w requires that s been signed t should be det	d by	POST-TROUM!	ATIC STRE	SS DIS	ORDER		1 🗀 Yes	s 2□No 3□Pr	obabiy 4 Dunknown
202	- D 0	lete	HICTORY OF	TUBORC:	4.0515			24a. Was an	24h. Were au	itopsy findings available
Vital Record	e la has je 2	Completed	Div Many Co	YPERTENS	/			autopsy perform	ed? prior to death?	completion of cause of
a	ician: Th certificate rector, pag	e C	PULMONARY H 25. Was case referred to medical	YIEFIENS	ION		26 Place of Dea	1 ☐ Yes 2, ath (Check only one		2 No :
5	Physician: this certificantal director,	To B	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	ent 3 DOA Othe			nce 6 Other (Spe	cify)
of	a Phy er this	n: T	27. Manne of Death	28a. Oate of Injury (Month, Day)	28b. Time	of 28c, Injury		28d. Describe how		
ion	Attending r death. ector: After by the fune	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		injury		res 2□No			
Division of	f or Attending Ph after death. Director: After th	tific	3 Suicide 6 Could not t 4 Homicide determined		y - At home, farm, s (Specify)	street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
O	spital or Attenous after deat ours after deat teral Director: filled in by the	Certification:	/							
	the Hospital or Athin 24 hours after the Euneral Dire	edical	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of e	xamination and/or i					
	To the Hos within 24 ho To the Fun completely	Med	one) 29b. Signature and title of certifier	and manner state	od.	20a Lungara	a cumber	مرد ا	d Date signed (Most	h Oay Vanel
	To To		250. Signature and title of certifier	1.A.M	fun Mr.) D4	46361		dul 10	2006
		1				Point			Link.	
			30. Name and address of person who	completed cause of dea	Itn (Item 23a) (Type	TERDAL IS	16HAM	Mine	esulla M	2006 0 21108
P. 90	St	ate	31. Date filed (Month, Day, Year)	32 Aegistrar	s Signature	a correspond	011111-19	1116	- some in	
	Reaist		JUL 177	2006	. K A	and .				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARGARET ANN HICKS JULY 24, 2006 8:35AMM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🗓 F Yrs 83 JAN.2,1923 MARYLAND Director 217-60-7223 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examination must be inclined at once. 1 ☐ Yes 2X☐X\o MARYLAND PRINCE GEORGE'S Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20735 U.S.A. 9106 PINEVIEW LANE by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes XXXNo fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Si Widowed 4 □ Divorced BLACK Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN SELF HOMEMAKER 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MINNIE CHASE GEORGE BRADRICK CHASE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12150 ELL LANE, APT. #209, WALDORF, MD 20601 VIOLA GIBSON-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ST.MARY'S CH. CEM. 7-31-06 NEWPORT, MARYLAND 4 □Donation 5 □ Other (Specify) 22. Name and Address of Fact RAYMOND FUI 21. Signature of Fureral Service Licenses FUNERAL SERVICE, P.A. MARYLAND 20646 LA PLATA, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **ACUTE** MYOCARDIAL **Physician** INFARCTION /Medical Due to (or as a consequence of): Examiner ARTERY DISEASE CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physicien for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9□ Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate hes been signed rector, page 2 should be de-Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Tes 2 No Division of Vital fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 2 1 Yes 2 No 3□ DOA this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Medical Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 24 hours after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JOORIE D40324 JULY 24, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURRAITS ROAD, CLINTON, MARYLAND TERRY JODRIE, MD 7503 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 24280 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2006 July **Physician** 26, Joan Horan 4:55pm M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Glade Valley Nursing & Rehab Ctr Walkersville If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 X F Director 577-50-0100 7/21/1935 Washington, D.C. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, it is Medical Examinar must be notified at 1 ☐ Yes 2 🖾 No Director Frederick Clarksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20871 2611 B Prices Distillery Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. ant: If item 27 le marked other then "neturel", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Bartimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No by Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Interior Decorator Interior Decorating 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles W. O'Donnell Montaha Safedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6836 Snow Goose Court Frederick, MD 21703 Kathleen M. Cleveland Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
eny injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemet. 7/31/2006 | Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney & Basford P.A. F. H. M00176 106 East Church Street Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Immediate Cause (Final Kenal Coll Carcinima **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Embeltom Klmmary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physicien end s the burial-transit Fibrillation Atrica that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the been signed by the ettending should be deteched for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ NO 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificete has t lirector, page 2 s autopsy performed? 2□ No 1 Yes 20 No 1 Tyes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 42 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2₽No ဥ 2 ER/Outpatient ₽ 3 DOA this Director: After the in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. М 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours are within 24 hours are To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier icai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Maroh 1 046248 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Dr. Martha J. P. 31. Date liled (Month, Day, Year) Pierce M.D. 300 West Ninth Street Frederick, MD 21701 32. pegistrar's Signature_ State

DHMH 17 Rev 1/2001

Registrar

AUG 0 2 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20<u>06</u> **Physician** July 13, William Arthur Hall 11:19 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5217 Kenmont Road, Prince Georges Oxon Hill, MD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1/25/1931 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Virginia Westmoreland Cty **Funeral №** M 2□ F 228-32-7006 75 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or iteme 23a or 28e-f ehow the Medical Examinar must be notified at Maryland Prince Georges Oxon Hill X□Yes 2□No Directo 10g. Citizen of What Country? United States 10e. Street and Number 5217 Kenmont Road 10f. Zip Code 20745 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black δ Specify: 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Heavy Equipment Operator Gas Utility Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be William D. Hall Sarah E. Braxton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Haelth ar important: If item 27 le eny injury or other trau Lucille W. Hall (Ex-Spouse) 420 Irving Street, NW, Washington, DC 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Zion B. Crematory or other place) 7/22/2006 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Tucker-Hill, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Jicenses Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville,MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovascular **Physician** pertensice /Medical to (or as a consequence of) Examiner S— uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): to the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge death occurred at the time, determined at the time, date and clue to the cauca(e) and manner acritated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified MD 13374 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1140 Varnum Street, NE, Washington, DC, Robert P. Williams, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 1 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Virginia E. Hall Ju₁y 11, 2006 10:30P [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Charles 11344 Teakwood Drive Waldorf If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F 74 Yrs. Director 230-36-3490 March 26, 1932 Virginia Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits 27 is marked other than "natural", or items 23s or 28s-f show treumatic event, the Mudical Expirator inust be notified at Charles Maryland Waldorf 1 X Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11344 Teakwood Court 20603 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after of Hygiene.

other than "natural", or iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify **Black** Specify: 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Custodial Worker Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t and 2 should be fill Heelth and Mental Heelth and Mental Heelth and Mental Heem 27 is marked oth Robert Ashton Virgie Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale Hall/Daughter 11344 Teakwood Court; Waldorf, Md. item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important; if any injury or once. July 18,2006 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Arlington, VA. Pope Funeral Homes 5538 Marlboro Pk. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20747 Forestville, Md. 23a. Part1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CVA /Medical Due to (or as a consequence of): Examiner Seizure Disorder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit HTN Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physiclen Physician/Medicai PVD the 159 es attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ned by the a detached f 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Completed by 8 S/P G Tube 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has 1 Yes 212 No To the Hospital or Attending Physician: within 24 hours efter Geath. To the Funeral Director: After this manifum tor: After this certific the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ 1√0 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 Yes 2 No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 I Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) S- m MD8172 July 17, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khosrow Davachi, M.D. 1328 Southern Ave. SE; Suite 310; Washington, DC. 31. Date filed (Month, Day, Year) State Registrar JUL 1 8 2006

State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 12:38 PM Elsie Gray Hagans 100G /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince George If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔀 F 244-38-3911 80 Vrs 8, 1926 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-1 ehow other treumatic event, the Medical Examiner must be notified at Maryland Prince George Lanham 1 XYes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7008 Nashville Court 20706 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🖾 No Specify: Black ģ 3 X Widowed 4 □ Divorced "netural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Government Library Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny lighty or other treumatic event potes. Be Roosevelt Rush Neta Cameron ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Minnie Hagans/Daughter 7008 Nashville Ct; Lanham, MD. 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Memorial Cem. July 18,2006 Suitland, MD. Pope 5538 Funeral Homes Marlboro Pike 21. Signature of Funeral Service Lice see 22 Name and Address of Facility Forestville, Md. 20747 23a. Part1. Enter the disease, shock, or heart failure. or complications that caused the death. Do not ist only one cause on each line. enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCANOL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use es the burial-transit or Attending Physician: The law requires that the death certificate be executed attending physicien and for use es the burial-trar Due to (or as a consequence of): Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy perfor rmed? 2 No 1 Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death | Check only one 1 Yes ≥ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident within 24 hours after death

To the Funerel Director: ,
completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\tag{Homicide} To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 9500 ANNAPOLIS Rd AI LANHAM, MD 2076 LEACH M-D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

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	5.	Funeral		5. Social Security Number 6. Se	X M 2 F	7. Age (In yrs.	•		r 1 Year If Un	der 24 Hrs. rs Min.	8. Date of Bit (Month, Da	ay, Year)	Co	nplace (State or Foreign untry)
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		To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier 1 Cartifying Pt (Check only one)	niner: On the	e best of my kn basis of examin nner stated.	owledge, dea ation and/or i	ith occurre	d at the time, da on, in my opinion	te and place , death occu	, and due to the rred at the time	e cause(s e, date an	and manner as d place, and due	s stated. a to the cause(s)
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-		2		30. Name and addr of person who		use of death (Ite	m 23a) (Type	e, Print)					er it,	
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		artment of Health and Mental Hy tificate of Death	/giene Reg. No. 2006 24285
	Decedent's Name (First, Middle, Last)	2. Date of D Month	
Physician /Medical	PRESTON LEE HUDSON	07	17 2006 1009 M
Examiner	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER	4b. City, Town, or Location of Death SALISBURY	4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 82 Yrs.	Months Days Hours Min. Months Days Hours Min. NOV 03	9. Birthplace (State or Foreign Country) 1,1923 MILLSBORO, DE
ehow	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo DELAWARE SUSSEX FRANKFOR		10d. Inside City Limits 1 ☐ Yes 2 X No
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Maryland to 2 should be file the and to 18 streametic event retraumetic event To Be (19a. Informant's Name/Relationship (Type, Print) 19b. Mailir JOYCE BRITTINGHAM (DAUGHTER) 2115	ng Address (Street and Number or Rural Route Num 6 SHELL STATION RD., FI	
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Baltimore, bernit. Pages 1 at Department of Hea mportant: if tem any injury or othe ang.	21. Signature of Funeral Savit Licensee	ST CEMETERY 2. Name and Address of Facility ATSON FUNERAL HOME ILLSBORO, DELAWARE 19966	
3760, ate be executed Among a price burial-transit the burial-transit lical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	to rapular accident	Approximate Interval Between Onset and Death 2 1/2 whs
O. Box 61 O. death certific the attending p thed for use as t	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
ds, P.(ds, p.)	& A A	underlying cause given in Part I. 23e. Did	d tobacco use contribute to the cause of death? Yes 2 \(\text{No} 3 \) Probably 4 \(\text{Unknown} \)
Division of Vital Record of or Attending Physician: The law requirentedath. To the function of the certificate has been signed by the funcial director, page 2 should be entification: To Be Completed.	Micotone abuse	24a. Wi au pe 1 □ Yes	topsy prior to completion of cause of death?
F Vital Raysidan: The yelden: The director, page	25. Was case referred to medical examiner?	26. Place of Death Check on	
Vision of Vital Attending Physician: Geath. sctor: Atter this certification to the funeral director; p. Iffication: To Be C	1 ☐ Yes 2 No Hospital: 1 X Inpatient 2 ☐ ER/Outpatien		sidence 6 Other (Specify) e how injury occurred
Division of tell or Attending P is eliter death. at Director: After tell or the funers ed in by the funers.	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of fnjury - At home, farm, st building, etc. (Specify)	reet factory office 28f. Location	(Street and Number or Rural Route Number, Town, State)
Hospite 4 hours Funeral tely filled		th occurred at the time, date and place, and due to the occurred at the time, dath occurred at the time.	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
To the within 2 To the complex	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
BA 5+1	30. Name and address of person who completed cause of death (Item 23a) (Type NICHBLAS J. DUDAS 145E. C		21 MD 21801
State Registrar	31. Date filed (Month, Day, Year) 32. egistrar's Signature	back	

DHMH 17 Rev 1/2001

Registrar

JUL 1 9 2006

		-	For State Registrar	state of Maryland /	Depa Cer	rtment of H tificate of L	ealth and M D <i>eath</i>		ene 2 0 0 6	24287
ı	Physicia		Decedent's Name (First, Middle, Last)	James				2. Date of Death July 6,		3. Time of Death 8:00 A M
	/Medic Examin	er	4a. Facility Name (If not institution, give stre 9109 Ridgewood Dri	ve		Fort Was	Location of Death shington If Under 24 Hrs.		4c. County of Dea	orge's
ı	Funeral Director		.01-36-3763	7. Age (In yrs. last 59	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept 25	Year) 1946 Manh	thplace (State or Foreign buntry) natten NY
	ehow	Į.	Usual Residence of Decedent	rge's Fort		ington				10d. Inside City Limits 11 Yes 2 □ No
	with the M Sa or 28a-1	i Direct	10e. Street and Number 9109 Ridgewood Driv	e		10f. Zip Code 20744			Og. Citizen of What Co	
920	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "netural", or Items 23a or 28a-f show important: if Item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other treumatic event, the Marical Examinar must be notified at appear.	by Funeral Director	11. Marital Status 1 Never Married	Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 No 1967 Il Yes, Give 1970 Year or Dates: 1970		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 21 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify: B1a	te, etc.
2-612	ithin 72 house.	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	ion 1 ompleted) College (1-4or 5+)	(Give I life. E	ent's Usual Occupa kind of work done of OO NOT use retired	during most of work)	ing	16b. Kind of Business	
Jana z	be filed w ntal Hygier od other th	Be	12 3 17. Father's Name (First, Middle, Last) Milton James		70.110	e Office	18. Mother's Nam		aw Enforce Maiden Sumame)	ement
	should nd Mer mark maric	은	19a. Informant's Name/Relationship (Type,	Print)	9b. Mailin	g Address (Street a			City or Town, State,	Zip Code)
Z	alth ar 27 is		Joanne James /Wife			_			ington MD	
saitimore,	Pages 1 and the ment of He ant: if item		20a. Method of Disposition ¹XXBurial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place cerm Mary Cemet	Land	sition (Name of natory or other place Veteran	's 7-13-	2006 C	20c. Location - City or heltenham	
Dall	permit. Departimport. eny inj		21 Dignature of Funeral Service Licensee	Davis	- 22	Name and Addres	-		Home 11e MD 207	47
	Physician /Medical		23a. Part1. Enter the disease, or complical shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the death. It cause on each line. Due V (or a consequent	61	CINOMA	g, such as cardiac		est,	Approximate Interval Between Onset and Death
	Examiner transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen						
8/60,	cate be executed physicien and the burial-transit	dicalE	d.	Due to (or as a consequen	Ce (i).					
C. Box 6	at the death certifi by the attending I tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, P	quires that n signed b uld be deta	þ	Part II. Other significant conditions contri	buting to death but not resulting	ng in the ur	nderlying cause giv	en in Part I.		pacco use contribute t es 2 □ No 3 □ P	o the cause of death? robably 4 □Unknown
Vital Records,	hysician: The law requires that his certificate hes been signed b I director, page 2 should be deta	Completed						24a. Was a autops perform	y prior to ned? death?	utopsy findings available completion of cause of
Z Z	iclan: certific rector,	Be	25. Was case referred to medical examiner?	spital:	· · · · ·	. ac pos Oth	00	h (Check only on		
Division of	ing P	itlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 LER	Outpatien b. Time of	28c. Injur Wor	4 Nursing H		ence 6 Other (Spenier) ow injury occurred	эспу)
Divisi	ospitel or Attend hours after death unerel Director: / ly filled in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	a, larm, str	eet, lactory, office		28l. Location (St City or Town	reet and Number or F n, State)	lural Route Number,
	I 4 IL 0	Medical (29a. Certifier (Check only one) 1 Cartifying Physic 2 Madical Examina	tian: To the best of my knowle r: On the basis of examination and manner stated.	dge, death and/or in	n occurred at the tirvestigation, in my o	ne, date and place, pinion, death occu	and due to the cared at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
)	To the within 2	×	29b. Signature and title of certifier.	mou in	N	29c. Licens	-784 (nd)	9d. Date signed (Mon 7/11/06	th, Day, Year)
g	CIVA		30. Name and address of person who com	snow, MD	5	O Irv	ing St.	N.W. h	lash. D.C.	20422
	St: Regist	ate rar	JUL 1 7 2006	32. Registrar's Signatur	E)		J ,			

Lawrence Phillip Jones

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

awience Fillip	1	- For State	Cert	tificate of				. No. 20	06 2428
Physicia	ın/	1. Decedent's Name (First, Middle,Las					2. Date of Death Month	Day Year	3. Time of Death 2017 hrs
Medical Examii		Lawrence 4a. Facility Name (if not institution, giv			4b. City, Town, or	Location of Deat	July 8, 2006	4c. County of Dea	
()		Suburban Hospital	o ou out and memory		Bethesda			Prince Georg	
Funeral		5. Social Security Number 6. Se	ex 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days			(MM/DD/YYYY) 9. E Fore	eign
Director		432-32-2197	M 2 F 79	Yrs		S Hours Will	April 10	, 1927 C	Country) Arkansaa
ń		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Locat	ion		<u> </u>		10d. Inside City Limits
d now any		Maryland Prince (Penroe	Upper 1	Marlboro				1 X Yes 2 No
daryłand 28a-f show d at once.		10e. Street and Number	,	FF	10f. Zip Code		100	g. Citizen of What Co	
the M		10814 Brookwood A	Avenue			772		United S	tates
21215-0036 Mald be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 X Married	12. Was Decedent Ever in U. Armed Forces?	S. 13. Wa	as Decedent of His es, specify Cuban	spanic Origin? (S n, Mexican, Puert	Specify Yes or No- o Rican, etc.)	14. Race - Am White, etc.	erican Indian, Black,
P 9 E			1 X Yes 2 No 1 If Yes, Give Year 1946	1	Yes 2X No	specify:		Specify:]	31ack
urs aft ntural' amino	d by	15. Decedent's Education (Specify of	or Dates:	16a. Deceder	nt's Usual Occupat	tion (Give kind of	work done	16b. Kind of Busines	s/Industry
6 172 ho ran "ns	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	1	•	. DO NOT use te	ined)	Governme	nt
withir siene.	E.	12 17. Father's Name (First, Middle, Last	6	Pha	rmacist	18.Mother's Nam	ne (First, Middle, M		
21215-0036 suld be filed within 7 i Mental Hygiene. I marked other than ic event, the Medica	Be C	Matthew Jones)			Ikey Wa		,	
212 hould b nd Men is marl itic eve		19a. Informant's Name/Relationship (oer, City or Town, Sta	
ore, MD ss I and 2 sho of Health and If item 27 is		Sarah Jones/Spou			4 Brookw sition (Name of cer		Date	20c. Location - City	Md. 20772
		1 X Burial 2 Cremation 3	Removal from State	crematory or ot	ther place)				
Baltimore, permit. Pages I a Department of He Important: If ite	1	4 Donation 5 Other Specify 21. Signature of Funeral Service Lice			Veterans Name and Address	s of Facility	y 14,2006	ral Homes	ham, MD.
Ba perm Depa Impo injur		Ceva a	8 / chel	\mathcal{L}			rorestvil	ral Homes boro Pike le, Md.	20747
Physician		23a. Part I. Enter the disease, or comfailure. List only one cause on e	plication, that caused the death ach line.	not enter t	the mode of dying,	, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a	Exsanguination due to		emodialysis sh	nunt			Death
		or condition resulting in death) Sequentially list conditions	Due to (or as a consequence o	r):					
	ner	if any, leading to immediate	Due to (or as a consequence o						
_	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence o	f):					
760, icate be executed physician and the burial - transit									
60, ate be ex ohysician e burial	Medical	UNPENDED	AMENDED					23d. Date of deliv	(en)
876 tificate ng phy as the	M/u	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	2 F	etal death 3	Ectopic preg	nancy	Month	Day Year
Box 687 e death certific the attending 1 ed for use as the	Physician/	1 Yes 2 No 9 Unknow	4 Pregnant at time of de	eath 5 O	ther (Specify)				
5.0. Bothat the dended by the	Phy	Part II. Other significant conditions		esulting in the	underlying cause	given in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
, P.C ires that signed I	d by	Endstage renal disease,	hypertension				1 Yes	2 🗸 No 3 🔝 F	robably 4 Unknown
rds, requir	Completed by						24a. Was a autops	sy prior	autopsy findings available to completion of cause of
eco he law ate has	dmo						perform 1 Y Yes 2		
Vital Records, ysician: The law requir his certificate has been director, page 2 should	Be C	25. Was case referred to medical examiner?				e of Death (Chec			
of Vit ing Physic After this c	70 E	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 🗸	ER/Outpatien		Other Nurs		Residence 6 Of	her:
nding th r: Afte	ion:	1 Natural 5 Pending	Jul 8, 2006	1915 hrs		Yes 2 V No	rupture of dia	alysis shunt	
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the fact death and Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	ficat	2 Accident Investigat 3 Suicide 6 Could no	28e Place of Injury - At h	ome, farm, stre	eet, factory, office	building, etc.	28f. Location (S or Town, St		Rural Route Number, City
Div Hospital o 24 hours afi Funeral D	Certification:	4 Homicide determin	ed (Specify) Single Far	<u> </u>			10814 Brook	wood Avenue,	Upper Marlboro, MD
Division of Vital Records, P.O. Box 68760, To the Itospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. No the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Physicone) 2 Medical Examin	cian: To the best of my knowled er:On the basis of examination a	lge, death occu	urred at the time, dation, in my opinion	late and place, a n, death occurred	nd due to the cause d at the time, date a	e(s) and manner as s and place, and due to	started. o the cause(s)
To the within 7 to the Complet	Medical	29b. Signature and title of pertifier	and manner stated.		29c. Licen			29d. Date signed (
1 SH(4)	_	VIO	las DR.	441	0.0	.M.E.		July 9, 2006	
OLD		CO. Harris and The Control of the Co	come eted cause of death (Iten	n 23a)					
DE .			eputy Chief Medical Exa		11 Penn Stree	t, Baltimore,	MD 21201		
S Regis	tate	31. Date filet (Month Park (ear)	32. Registrar's Signat						

			For State Registrar	State	of Ma	rylan		artment <i>tificate</i>			ınd M	ental Hyg	jiene	211115	24289
	Physici /Medic		Decedent's Name (First, Middle W. 1	-	Sone	رکی	Sr.					2. Date of Dear	th Day		3. Time of Death
). 	Examin	er	4307 Cha	, give street and	number) Ro	and			alti	Location o		J		County of Death	
	Funeral Director		5. Social Security Number 230-42-6134 Usual Residence of Decedent	6. Sex 1 X □XM 2 □ I		(in yrs. i	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day) March	. Year)	, 1938 L	place (State or Foreign ntry)
	se Marylan	ctor	10a. State 10b. County				timor timor	e							10d. Inside City Limits 1. Yes 2 No
	eeth with it 1s 23s or 2 must be n	Funeral Director	10e. Street and Number 4307 Chatham 11. Marital Status		ecedent E	ver in U.	S. 13. V	10f. Zip	207	spanic Orio	nin? (Soe		И.	izen of What Cou	
9800	ours after d rei', or iten	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	ied 1 ☐ Ye	Forces?		1	f Yes, spec 1 ☐ Yes 2	rfy Cubai	Specify:	, Puerto	Rican, etc.)		Black, White, B sbedifc K	
21215-0036	should be filed within 72 hours after deeth with the Maryland and Mental Hyglene. marked other then "naturel", or items 23e or 28e-f show imatic event. It a Madical Examinar man be notified at	Completed	(Specify only higher Elementary/Secondary (0-12)		ө <i>d)</i> ө (1-4or 5-	+)	life. I	tent's Usua kind of wor DO NOT us k Dn.	k done d e retired,	luring most)	of worki	ng		ind of Business/Ir rstruct	
ਰ	Hygi Other	To Be Co	(9th 17. Father's Name (First, Middle, Roachie Jone	,						18. Mothe		White			
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If item 27 is marked eny injury or other treumatic ev 2008.		19a. Informant's Name/Relations Linda Jones-		л		8373	70w	nsh.		r. 0u	vin Mil	20 1	nr Town, State, Zij Md, 2111	7
timore	t. Pages 1 rtment of H rtant: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	om State	C	lace of Dispo emetery, crer , Loui	natory or of S Ch	Ce i	n	7-16	Date 5 - 2006	Ch.	ocation - City or T arlotte	own, State
■ Ba	permi Depa impo eny ii		21. Signatury of Funeral Service	complications th	at caused	the death	\widehat{L}		& S	ons	5635	5 Eads		, N. E.	Approximate
Sais	Physician /Medical		Afhock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	to (or as a	ng	uence of):	ncel	<u> </u>						Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to announce cause. Enter Underlying Cause (Disease or injury	b. — Disa	to (crass	(dunsek,	upnos of):	<u> </u>							
8760,	death certificate be executed e attending physicien and nd for use as the burial-transit	dicai Examiner	that initiated events resulting in death) Last	c. Due	to (or as a	consequ	uence of):								
Box 687	eath certificate attending phy: I for use as the	n/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome o	of pregna		Ectopic pre						23d. Date of deliv	ery
P.O. B	t the by th ache	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pi 9□ U	egnant at i	time of de	eath 5	Other (spe	ecify)	a ia Baat		22a Did to		Month	Day Year
	requires een sign hould be	þ	Part II. Other significant conditi	uns contributing i	o death bu	t not resi	und in the u	nderlying ca	iuse give	9η In Paπ I.		124	es 2	□No 3□Proi	he cause of death? bably 4 \(\sum \text{Unknown}\)
of Vital Records	The la ete hes page 2	e Completed	25. Was case referred to medica	1						Of Blace	of Dooth	24a. Was a autops perform	sy med?∕ 2 ☑ No	prior to co death?	opsy findings available ompletion of cause of
Ž	S 0 =	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	☐ Inpatier	nt 2 🗆	ER/Outpatier	nt 3 🗆 DO	A Othe	00				6 ☐Other (Speci	fv)
Division o	tending leath. tor: After the fune	Certification:	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	gation	ate of Injur Month, Day	Year)	28b. Time or Injury	М			No	28d. Describe he	ow inju	ry occurred	
Div	the Hospital or Attendin 24 hours after death the Funerel Director: pletely filled in by the		4 Homicide determ 29a. Certifier 1 Certifyin	ng Physician: No	uilding, etc	. (Specify	wledge, deat	h occurred :	at the tim	ne, date an	d place.	City or Town	n, State	and manner as	stated
\	To the Ho within 24 h To the Fu	Medical	(Check only 2 Medical one) 29b. Signature and little of certifie	and r	ne basis of nanner sta	examına	tion and/or in	vestigation,	in my of	number	th occurr	ed at the time, d	late and	d place, and due t te signed (Month,	Day, Year)
Ye	6		30. Name and address of person	12 .1	cause of de	eath (Item	23а) (Туре,	Print)	×0	028	(7)3	> /	7	11710	(b)
	Sta	ate	31. Date filed (Month, Day, Year)	000 e	2. Registra	r's Signa	ture	were 1	VV])	21	24	4 (1	بم	sen pen	minete)

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Ronald Wesley Johnson 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 15, 2006 1150 hrs Medical Examiner Ronald Wesley johnson 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Upper Marlboro 8705 East Grove Court If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or 7 Age (In yrs. last birthday) **Funeral** Social Security Number 216-68-2267 Foreian Months Days Hours Wash. Director Country) 09-05-56 1 x M 2 F 49 36-2655 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location 'n Upper Marlboro 1 X Yes 2 No Prince Georges 28a-f show MD death with the Maryland rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? fied at 20772 USA ä 8705 East Grove Court 23a notif 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Funeral 11. Marital Status 12. Was Decedent Ever in U.S. ist be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married 1 Yes Pages 1 and 2 should be filed within 72 hours after or the filed within 72 hours after or the and Mental Hygiene 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Black Widowed Examine ş r Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 h Department of Health and Montal Hygiene Important: If item 27 is marked other than "injury or other transmatic event, the Medical E. College (1-4 or 5+) Elementary/Secondary (0-12) U.S. Government un-av. 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Gloria W. Johnson Edward Evans ပ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5920 14th. St. N.W. #101 Wash. D.C. 20011 Gloria W. Robinson/Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Rock Creek Cem. 1 X Burial 2 Cremation 3 Removal from State 7-24-06 Wash. D.C. Donation 5 Other Specify: 22. Name and Address of Facility Marshalls Funeral Home 21 Signature of Funeral Service Licenses Jaisha 4217 9th. St. N.W. Wash. D.C. 20011 Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician allure. List only one cause on each line /Medical Death Ethanol and cocaine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Amend #5 Per FH G858-8/09/06 JH Physician/Medical X UNPENDED item#23a,27,28a-f,perME,g858,8/4/06 TT Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. by 1 ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? page 1 ✓ Yes 2 No 2 No certificate 1 🗸 Yes 26.Place of Death (Check only one) 25 Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA this 1 🗸 Yes 2 No ٩ 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: Natural 1 Yes 2 y No 5 Pending Fnd 7/15/2006 Fnd 11:45 am unk To the Funeral Director: the Accident

Investigation

6 X Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc (Specify) found at home

O.C.M.E

28f Location (Street and Number or Rural Route Number, City or Town State) 8705 Fast Grove Upper Mariboro, 1

(Year)

Upper Marlboro Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

July 16, 2006

2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	n my opinion, death occurred at the time, date a	and place, and due to the cause(s)
re and title of certifier	29c. License number	29d. Date signed (Month, Day, Ye

e and address of person who completed cause of death (Item 23a)

determined

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

3

1

Medical

Suicide

29b. Signature and title of certifier

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year, 6

Patricia Aronica-Pollak MD.



State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July 17° Physician 2006 10:15A.M Arthur Henry Joyal /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Pay, Year) June14,1915 9. Birthplace (State or Foreign **Funeral** Days 1 **T**M 2□ F Months Hours Min Rhode Island 91 Yrs Director 037-10-3574 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County il Hygiene. . other than "natural", or items 23e or 28e-f show vent, the Madical Exeminar must be notified at Prince George's Adelphi 1 ☐ Yes 2 No Maryland Completed by Funeral Director 10f. Zip Code 20783 10g. Citizen of What Country? United States 10e. Street and Number 2305 Lackawanna Street filed within 72 hours after death 12. Was Oecedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 □ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supply Supervisor Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important. If tem 27 is marked oth eny injury or other traumatic event once. Be Arthur Joyal Marie LeBeau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2305 Lackawanna Street Adelphi, Maryland 20783 Paul M. Joyal -son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 7/19/2006 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA Donald 1/1 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis Syndrome /Medical Due to (or as a consequence of) Examiner Clostridium Difficile Colitis S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the humin transal. Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Urinary Tract Infection; Dehydration; Renal Failure; 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Multiple Myeloma autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Oescribe how injury occurred 1 XNaturat 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Juyan D53367 July 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rajan Shyamsundar, M.D. 3411 Olandwood Court Olney, Maryland 20832 (suite#105) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 9 2006 Registrar

Amended Item 23e per Physician 07/18/2006 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [24292 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** July 2006 11:05 a Sandra Irene Janocha /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll 2321 Manchester Road Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 28 1938 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1□ M 25 F Yrs. 67 MD Director 219-34-6837 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or Items 23a or 28a-f ehow vent, the Medical Examiner must be notified at Westminster MD Carroll 1 ☐ Yes 2 XNo Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 USA 2321 Manchester Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item Z7 is marked other eny Injury or other treumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Thomas C. Boone Kathryn Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Janocha/son 2321 Manchester Road Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 7/18/2006 1 Burial 2 Cremation 3 Removal from State Evergreen Memorial Gardens Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): the attending physicien a thed for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ficate has been sig r, page 2 should b 3 Probably 4 Unknown 1 X Yes Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2/2 No 1 Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatore and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20

WJL 15

DHMH 17 Rev 1/2001

State Registrar

John W. Middleton M.D. 37. Date filed (Month, Day, Year) 32. Re 2006 JUL 18

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

GS8 Poole Rd, Westminster

			1 - For State Registrar AMEND #26 I	State of A PER PHYS	daryland / Dep 7/19/06 <i>Ce</i>	partment of leartificate of	Health a <i>Death</i>	nd Mental Hy	/giene 200	6 24293
	Physici		1. Decedent's Name (First, Middle, La. Donis Mae He		1A ON			2. Date of D Month	Day 200	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, giv			4b. City, Town, o	or Location of		4c. County of D	0
			13458 Overbrook			Bowie	1.1611-4-20		Prince G	
	Funeral Director		5. Social Security Number 123-38-8755 Usual Residence of Decedent	ex	Age (In yrs. last birthda Yrs.	y) If Under 1 Year Months Days		Min (Month, D	orth ay, Year) 27,1945 Vi	Birthplace (State or Foreign Country) LGÍNÍA
	yland iow		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	a Man	ctor	Virginia Louisa		Mineral					1 ☐ Yes 2 €No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	e 23e	erai	732 Rising Sun Ro	ad 12. Was Deceder	at Ever in II S	23117	lianania Osi-	:-2 (CX	USA	merican Indian.
S	r kerr	by Funerai	1 Never Married 2 Married	Armed Force:	s?			in? (Specify Yes or N Puerto Rican, etc.)	Black, W	
8	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	3:	1 ☐ Yes 2 ☑ No	Specify:		Specify:	Black
<u>5</u>	within 72 hours after death with the Maryland ene. than "neturel", or Iteme 23e or 28e-f ehow fre Modical Exercities transt be notified at	Completed	15. Decedent's Ed (Specify only highest gra		(Giv	edent's Usual Occup re kind of work done DO NOT use retire	during most	of working	16b. Kind of Busine	ss/Industry
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Maryland 21215-0036	e filed al Hygid l other vent, il	Be C	17. Father's Name (First, Middle, Last)		1,	200001000	18. Mother	's Name (First, Middle		
yla	ould be I Mental harked o	To I	Edmund Henson					h Johnson		-
Mar	d 2 sh th and th sm treum		19a. Informant's Name/Relationship (oer, City or Town, State	e, Zip Code)
	s 1 end f Health item 27 other tr		Sandra Watkins/D 20a. Method of Disposition		20b. Place of Disg			ne Bowie M Date	20c. Location - City	or Town, State
E I	Pages nent of I ant: If its ary or o		1 Y Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		10	Crematory	1	7/21/2006	Charlotte	ville Va
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show eny finury or other treumatic event, the Medical Examinating must be notified at anotes.		21. Signature of Fu	1500		22. Name and Addre	ss of Facility	Thomasson	Watson Fun	eral Svc, Inc.
	<u></u> <u>0</u> 0 5 € 0		23a. Parti Enter the disease, or com	Tody	1261	117 West	Stree	t Louisa, V	irginia 23	093
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Bec	helaw shasi ge 2 s	ldmo	- Harripia	eynea	7			24a. Was	psy prior death	autopsy findings available to completion of cause of ?
ta	an: T tificate tor, pa	Φ	25. Was case referred to medical	wen	1710		26 Pface of	1 ☐ Yes of Death (Check only)	2 1 √ Yo 1 ∨ Y	
<u>></u>	hysici his cer I direc	ToB	examiner? 1 Tes 2 No	Hospital: 1 ☐ fnpa	tient 2 ER/Outpatie	ent 3 DOA Oth			dence 6 10 Other (S	DAUGHTER Decity) HOUSE
Division of Vital Records,	Attending Physician: It death. ector: After this certifica by the funeral director.		27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of In (Month, D	jury 28b. Time Day Year) Injury	Wo		28d. Describe	how injury occurred	
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	tal or A		4 Hornicide	building,	etc. (Specify)			City or To	wn, State)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best niner: On the basis	st of my knowledge, dea of examination and/or i	th occurred at the tinnvestigation, in my o	me, date and opinion, death	place, and due to the occurred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
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>	2 27		30. Name and address of person who	ompleted cause of	death (Item 23a) (Type	/ ///	11 /	2 . 0 06 0	2012	8/2006 e,MD20716
	D 🔏 Sta	te.	31. Date filed (Month) Day, Year)	BZ. Redis	trar's Signature	1 TChelly1	11e k	Dad STEF	LUY DOWN	e, MU 20716
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		1- For Amend Item 1 Registrar	State of Marylar per Dr., G858,	08/01/	artment of H 06dhb rtilicate of t	lealth and Death	d Mental Hyg	giene No. No. 2	006	242	294		
		1. Decedent's Name (First, Middle, Last)	William Thom	son Jo	hnstone J	Ir.	2. Date of Dea		Maria	3. Time of	Death		
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/Mec Exam		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of De		4c. Cou	nty of Death				
Exam	mer		and Medical C	enter	Beltim	oce		~	IA				
Funera		5. Social Security Number 6. Sec			If Under 1 Year	If Under 24 H		7	9. Birthpl	ace (State o	or Foreign		
Directo		290-38-3670	^{™ 2□ F} 62	Yrs.	Months Days	Hours M	in. (Month, Da)		New Y	ork			
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r 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Coun	try?			
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deat	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent of H	lispanic Origin?	(Specify Yes or No-		Race - America Black, White,				
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should be nd Mental marked c	ို့	William Thomson Jo	ohnstone			Mary H	. N. Hugh	ey					
S DE E	1	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Maili	ng Address (Street	and Number or	Rural Route Numbe	r, City or To	wn, State, Zip	Code)			
		Daphine Johnstone/	Wife	6442	Suicide	Bridge	Road, Hur	lock,	Maryla	nd 216	643		
s 1 a if Hea if Hea othe		20a. Method of Disposition	1	Place of Dispo	osition (Name of matory or other place	ce)	Date	20c. Locatio	on - City or To	wn, State			
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To the Hospital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the													
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		30. Name and address of person who c											
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			Registrar 1. Decedent's Name (First, Middle, Last)		tinoate or i	Douth	2. Date of Dea			3. Time of Death
	Physici /Medio		HERBERT HARR	Y KALIN				Month JULY 2	Day 21, 200	Year 06	1:15P M
j	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of Death		4c. County	of Death	
			SOUTHERN MARYLA			CLINT			PRINCE		ORGE'S
	Funeral Director		5. Social Security Number 6. Se	x 7. Age (In yrs. XM 2□ F	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)		lace (State or Foreign try)
			084-26-5513 Usual Residence of Decedent	72				FEB.16	5,1934	NEW	YORK
	ehow		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10	Od. Inside City Limits
	Be-f	Director	MARYLAND CHARL	ES	WALDO	RF					1 ☐ Yes 2 🔀 No
	vith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of V	√hat Coun	try?
	death with the Maryland me 23a or 28e-f ehow rmust be notified at	erai	12861 OWENS DRI	VE 12. Was Decedent Ever in U	IS 12 1	206		acifu Vas or No.	U.S.	A . e - America	an Indian
0	be filed within 72 hours after death with the Marylan ital Hyglene. Id other then "naturel", or Iteme 23s or 28e-1 ehow other then "naturel", or Iteme 23s or 28e-1 ehow event. The Mazical Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give		f Yes, specify Cuba 1 ☐ Yes 2़ंΩNo	lispanic Origin? (Sp an, Mexican, Puerto Specity:	Rican, etc.)	Blac	k, White, e	etc.
3	hour		15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usual Occup	ation		16b, Kind of Bu		
0	n 72	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of work d)	ring	TOD. THIS OF DE	311103341110	, doiny
7	d with	mo;	12	4	ENT	ERTAINE	R .		OWN SE	ELF	
2	2 should be filed and Mental Hygis is marked other eumatic event, I	Bec	17. Father's Name (First, Middle, Last)		11000	CECEINI SC	18. Mother's Nam	e (First, Middle,	<i>Maiden Sur</i> nam	e)	
<u>X</u>	should bants a marked	To	ROBERT ROSS KA	LIN			SYLVI	A BARBE	R		
			19a. Informant's Name/Relationship (T)			•	and Number or Rur		,		Code)
บ้	1 and Health em 27 ther ti		SUZAN KATES-DA 20a. Method of Disposition			85 CEDAL sition (Name of	R LANE,	NEWBURG Date	20c. Location -		wn State
2	Pages nent of I nnt: If ite		t ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, crer	natory or other plac	(e)			,	
Dalilli	프를로		Donation 5 ☐ Other (Specify) 21. Signature of Furteral Service Licens			EMORLAL 2. Name and Addres		7-28-06	WALDO)RF,N	MARYLAND
ם	Department of the concession o		my	A 1004		RAYMOND	FUNÉRAI			Α.	
1	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the deal ne cause in each line. a			g, such as cardiac				Approximate Interval Between Onset and Death
,00	ificate be executed by physicien and street burial-transit	ıi Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	juence of):	PIRTERY	D/54	185			<u>-</u>
00/00	ficate f	edicai		d		· · · · · · · · · · · · · · · · · · ·					
O. DOX	death cert e attendin	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnant 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delive	ry Day Year
us, r	uires that n signed b	d by Pl	Part II. Other significant conditions co	ntributing to death but not res	,	nderlying cause give	en in Part I.	23e. Did to			e cause of death? ably 4 □Unknown
Decora	e la has	Completed	HYPERTENSION					24a. Was a autops perfor	med? d	rior to con leath?	osy findings available npletion of cause of
<u>v</u>	en: T tifical tor, p	0	25. Was case referred to medical				26. Place of Deat			Yes	2 L No
<u> </u>	nysici lis cer direc	To B	examiner? 1 Tes 2 No	lospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Othe	0.0	me 5 Resid		er (Specify)
5 5 0	nding Pt th. : After th s funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	y at k? Yes 2 ☐ No	28d. Describe h	ow injury occurre	ed	
DIVISION	al or Atte after des Directo d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	eet, factory, office		28f. Location (S City or Town	treet and Numbe n, State)	er or Rural	Route Number,
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag	edicai (29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knoner: On the basis of examinating and manner stated.	owledge, death	occurred at the time vestigation, in my of	ne, date and place, pinion, death occur	and due to the cred at the time, d	ause(s) and mai late and place, a	nner as sta ind due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	1		29c. License	e number	2	9d. Date signed	(Month, E	Day, Year)
)			· CA	M		1)/2	2906		7/2	4/1	56
	6		30. Name and address of person who co	ompleted cause of death (Iter	n 23a) (Type,	Print)	1	_ \ /	10	1	
	Ψ		31. Date filed (Month, Day, Year)	MS. 12000	old	unclen	HV+20	1, wal	dox+, M	00	0602
	Sta Registr		AUG 0 2 200	32 Registrar's Signa	A Andrew	well					

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State	of Marylar	•		nt of Ho te of E		ind M		giene Reg. No.	2006	24298
			1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medic		Eugene	B1.	aine		Kis	amore	9				1, 2006	20:20 M
	Examin		4a. Facility Name (If not institution,	give street and n	umber)		4b. City	, Town, or	Location of	f Death		4c.	County of Death	
			MEMORIAL HOSPIT	AL				BERLAI					LEGANY	
	Funeral			6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Und Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da)	v. Year)	Cour	lace (State or Foreign
Į.	Director		Usual Residence of Decedent		77	TIS.					10/15/	1928	West	Virginia
	land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation			-			1	0d. fnside City Limits
	Mary Febr	Ö	MD Alle	gany.		F	lint	stone						1 ☐ Yes 2 ☑ No
	28s	Je C	10e. Street and Number	Sarry				ip Code				10g. Citiz	zen of What Cour	ntry?
	3a ol	=	21101 Snow F	Hill Lane	s			211	530				USA	
	death me 2	Funeral Director	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13.	Was Dec			in? (Spe	cify Yes or No- Rican, etc.)		14. Race - Americ	
0	after or ite	Ē	1 ☐ Never Married 2 🔀 Marrie	Armed F ed 1 Tes If Yes, G	2 No	1			n, mexican, Specify:	, Puerto F	rican, etc.)	1	Black, White,	
3	ours	d by	3 Widowed 4 Divorced	Year or	Dates:		1 🗆 Yes	2 X 140	эрөспу.				Specify: Whi	te
ก็	be filed within 72 hours after death with the Maryland Hygiene. A the Hygiene of other than "naturel", or iteme 23a or 28s-f ehow avent, the Maulcel Examinar wast be notified at	Completed	15. Decedent' (Specify only highes	s Education f grade completed)	16a. Dece (Give	dent's Us kind of w	ual Occupa ork done d	tion uring most	of working	ng	16b. Kir	nd of Business/Inc	dustry
7	han within	ם	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.							0 4	- 4: •
7	iled v lygie ther t nt, th		12 17. Father's Name (First, Middle, L	actl			iru	k Dri		r's Name	(First, Middle,	Maiden	Constru	action
	ntal hed of	Be	Blaine	Euge	ne	Kisamo	are		Magg			rgir		elson
_	2 should and Men is marke sumatic	မှ	19a. fnformant's Name/Relationsh					s (Street a					Town, State, Zip	
2	and 2 seeth ar n 27 is		James D. Kisamo				-						Marylar	•
ע	Hee Item		20a. Method of Disposition		20b. I	Place of Dispo	sition (Na	ime of			ate		cation - City or To	
2	Pages nent of I int: If it iry or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		n State	ce <i>m</i> etery, crei samore				7/18	/2006	Riv	verton, V	ΛV
	그 등 원 중		21. Signature of Funeral Service L		, ILL									Home, P.A.
ŏ	Depariment of the popular in popu		Kade &	61							Cumber			1502
ı			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that	caused the dear	th. Do not ent	er the mo	de of dying	, such as c	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
, 1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		sitatio		eum	onic	λ				١	+ days
	Examiner			Due to	o (or as a consec	quence of):)
		ē	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a consec	quence of):								
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
5	exec an an iai-tr	Exa	resulting in death) Last	Due to	o (or as a consec	quence of):								
	cate be executed physicien and i the burial-transit	dicai		d										
9	ng ph as th	Ved	IF FEMALE:				-							
5	th ce tendii r use	an/	23b. Was decedent pregnant		utcome of pregnation birth 2 Feta		Ectopic	oregnancy				2	3d. Date of delive	
	res that the death certific igned by the attending p be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Preg 9☐Unk	nant at time of c	death 5□	Other (pecify)					Month	Day Year
	d by letach	Phy	Part fl. Other significant condition	ne contributing to	death but not rec	rulting in the u	ndoshina		n in Port I		230 Did to	hacco u	so contribute to th	ne cause of death?
ŝ	signe	þ	7 art II. Other significant correction	na contributing to	JOAN DUTTION 165	saiding in the d	idenying	cause give	miran.		1 🗆 Y		/	abfy 4 □Unknown
5	w require been sig should b	Completed												
	has has	m p									24a. Was autop	SY	prior to cor death?	psy findings available apletion of cause of
5	n: The ficete or, page	e Co	OF Man and referred to medical								1 ☐ Yes	2 No	1 ☐ Yes	2□ No
5	sicie certi	o Be	25. Was case referred to medical examiner?	Hospital:	Inpatient 2	ER/Outpatier	ıt 3∏ [Othe	~		(Check only or		Other (Specify	
5	Phy or this oral o		27. Manner of Death		of Injury oth, Day Year)	28b. Time of		28c. Injury Work			8d. Describe h			//
5	ath. T: Aft	atio	1 ☐ Katuraf 5 ☐ Pending 2 ☐ Accident investig		ntin, Day rear)	fnjury	м		? 'es 2 □N	lo				
2	Atte	H	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Plac	e of Injury - At h	ome, farm, str	eet, facto	ry, office		2	8f. Location (S City or Tow	treet and	Number or Rura	I Route Number,
5	tai or rs afte ei Dir ed in	Certification:		Ja	anig, oto. (opcon	.,,						n, olato,		
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeric Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medicai	29a. Certifier (Check only one) Certifying	Physician: To the xaminer: On the	ne best of my kno basis of examina nner stated.	owledge, death ation and/or in	occurre vestigatio	d at the time n, in my op	e, date and inion, death	place, a	nd due to the d d at the time, d	ause(s) date and	and manner as st place, and due to	ated. the cause(s)
	o the	Me	29b. Signature and title of certifier				2:	c. License	number		1	29d. Date	signed (Month, i	Day, Year)
•	10		•	H.Chot		-		n F	8853			-	7/15	106
-	7 - 10		30. Name and address of person v	who completed cau	use of death (Iter	m 23a) (Type,	Print)	כע	0000				1 - /	
,	n D		CHOTANI, HABIB	A., M.D.	, 130 PI	ENNSYLV	ANIA	AVEN	UE, C	CUMBE	RLAND,	MD	21502	
	Sta Registr		31. Date filed (Month, Day, Year)	006 3%	Registrar's Signa	ature /	anth s							

06-05256 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Debra Wiens Kidwell 2006 24297 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day July 20, 2006 1225 hrs Medical Examiner Deborah Wiens kidwell

4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c County of Death Montgomery Potomac 11825 Hunting Ridge Court If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex 7 Age (In yrs. last birthday) **Funeral** Months Davs Hours Min Director Country) Yrs Turkey 1 M 2 F 1953 578-62-9443 53 Jan. 7. Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No s 23a or 28a-f show notified at once. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Deparment of Health and Mental Hygiene.
Important: If item 27 is named other than "natural", or items 23a or 28a-f sho
figury or other reaumait event, the Medical Examiner must be notified at once. Potomac Maryland Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20<u>854</u> U.S.A. 11825 Hunting Ridge CT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral Was Decedent Ever in U S 14. Race - American Indian, Black, or items must be White, etc. Armed Forces? 1 Never Married 2 Married Yes Yes, Give Year Yes 2X No specify: 3 Widowed Divorced Specify: White 5 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Commercial Real Estate 4 Property Manager 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Iasbel Ferguson Henry Wiens 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11825 Hunting Ridge CT Potomac, Maryland 20854 W. Whit Kidwell / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State National Crematory 4 Donation 5 Other Specify: 07/28/06 Falls Church, Va. 22. Name and Address of Facility 21. Signature of Funeral Service License Joseph Gawler's Sons, INC. δ 51<u>30 Wisconsin</u> Ave NW Washington D.C. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Acute alcohol Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit sician/Medical XUNPENDED AMENDED item#23a,27,28a-f,perME,g858,8/4/06 TT Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been a funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 2 No No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other₄ DOA Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 Yes 2 No 5 Pending Fnd 7/20/2006 Fnd 11:30 am

To the Hospital or Attending Physician: within 24 hours after death Division neral Director: within 24 hours a. To the Funeral E

Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide determined (Specify) Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

Susan Hogan MD. 31. Date filed (Month Day,

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature any

> 8 2006

and manaer stated

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 32. Registrar's Signature O.C.M.E.

29c. License number

29d. Date signed (Month, Day, Year) July 21, 2006

28f. Location (Street and Number or Rural Route Number City or Town, State) 11825 Hunting Ridge Cour

Potomac, MD

111 Penn Street, Baltimore, MD 21201

State

Medical

partie

Found: Residence

		State of	Maryland		rtment of H tificate of L			giene	36 2	4298		
	1. Decedent's Name (First, Midd	le, Lest)					2. Date of De Month			ime of Death		
Physician /Medical	ALICE	RAPP	KELLY	/			JULY	15 200		30 AM		
Examiner	4a Fecility Name (If not institution			`ontov		b. City, Town, or L		1				
	Montgomery Vil 5. Sociel Security Number		n lare (7. Age (In yrs. las		INO If Under 1 Year		O Date of Di-	uL.	9. Birthplace (State or Foreign		
Funeral Director	577-12-6846	1□ M 2⊠ F	85	Yrs.	Months Days	Hours Min.	Month, Da April 1	y, Year) .7 1921		irginia		
P .	Usual Residence of Decedent 10a. State 10b. County		100 City 3	Town or Loc	ation				10d Inc	side City Limits		
the Marylan rottred at rector		tgomery			rsburg					Yes 2 □ No		
the N	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Country?			
3a or	874 Quince Or	chard Blvd	., #102			20878		United	States			
urs after death with the Mar ali, or items 23e or 28e-f si crandrer must be notified by Funeral Director	11. Marital Status	12. Was Dece Armed For	dent Ever in U,S.	13. W	/as Decedent of Hi Yes, specify Cuba	spenic Origin? (Sp	pecify Yes or No		e - American Ind	ian,		
or its	1 Never Married 2 Mar	ried 1⊠Yes If Yes. Giv	2 □ No e	1	☐ Yes 2 No	Specify:	7 110411, 0101,	Specify	,			
hours turel',	3 ☐ Widowed 4 ☑ Divorced			-	ent's Usual Occupa	ation		16h Kind of Bu	Whit			
be filed within 72 hours after death with the Maryland tell Hygiene. d other than "natural", or items 23a or 28a-f show ovent, it e Medical Evandrien must be notified at Be Completed by Funeral Director	(Specify only highe	nt's Education est grade completed)		(Give k	ind of work done a O NOT use retired,	uring most of work	king 16b. Kind of Business/Industry					
permit. Pages 1 end 2 should be filed within Department of Health and Mentel Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, I.e. Monce.	Elementary/Secondary (0-12) 12	College (1		Admin	istrative	a Assista	int	U.S.	Governme	ent		
el Hygent,	17. Father's Name (First, Middle,					18. Mother's Nam			10)			
Ment Ment Ment arked atic	Alfred Milto		4			Clara	Ella	Cline				
12 short and risman	19a. Informant's Name/Relations Paula B. Lake				Address (Street a							
1 end Healtt sm 27 ther 1	20a. Method of Disposition	, Daugiree	20b. Plac	e of Dispos	l Perciva	1	Date Date	<u> </u>	ia 2383 City or Town, SI			
T in a general and a general a	1 ☐ Burial 2 ☑ Cremation		State cem	etery, crem	atory or other place		110/06					
artme ortani Injury	/		/18/06	Alexand	dria, Va	1.						
permij Depar Impor any Ir	4 Donation 5 Other (Specify) Metropolitan Crematory 7/18/06 Alexandria, Va. 21. Signature of Funeral Service Licensee Muriel H. Barber Funeral Home											
	23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset and Death											
Physician	Onset and Death											
/Medical Examiner	disease or condition resulting in death) a. TO DECEMBER ON THE COLOMBIA.											
A CONTRACTOR	Due to (or as a consequence of):											
uted d ansit	b. Here 80 Cet. Due to (or es e consequence of):											
exectan and riel-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
cate be executed physician and sthe buriel-transit	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or as		ence of):							
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at the death certific d by the attending p eteched for use es Physician/Mee												
0 0 0	Part II. Other significent condition	ons contributing to de	ath but not resultir	ng in the un	derlying cause give	en in Part I.		tobecco use con Yes 2 [®] Q No		euse of deeth? 4 □ Unknown		
es that igned b be dete by PI							1	165 200 140	3 Fredbably	4 Olikilowii		
law requires that the as been signed by th 2 should be detechen appleted by Phys								an autopsy	24b. Were aut available	prior to		
The law requir sate has been s page 2 should Completed									of death?	on of cause		
The ate h							10	Yes 25 No	1 ☐ Yes	2 No		
sicien: The law certificate has the sirector, page 2 stores of the complete of	25. Was case referred to medica examiner?	Hospital:			o□ po ≜ Othe	26. Place of Deal						
Physic rthis c aral dire	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date o	of Injury 28	NOutpatient Bb. Time of	3□ DOA 28c. Injury Work	4EX Nursing Ho		dence 6 Other				
oding th.: Afte e fune	1 ☑ Natural 5 ☐ Pendii 2 ☐ Accident investi	ng (Monta igation	h, Day Year)	Injury		(? Yes 2 □ No						
tal or Attending P is efter death. el Director: After ted in by the funerated in Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place	of Injury - At home	e, farm, stre	et, factory, office		28f. Location (Street and Numb	er or Rural Rout	e Number,		
Itai or irs efte el Dir led in												
he Hospit in 24 hour he Funere pletely fills edical (ng Physician: To the Exeminer: On the ba	sis of examination							ause(s)		
To the Hospital or Attending Physicien: within 24 hours efter death. To the Funerel Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (29b. Signature and title of certific	and mann	IOI SIAIOU.		29c. License	number		29d. Date signed	d (Month, Day, Y	'ear)		
F 5 F 5	λ	10			He	05129	රිල්	7-13	7-06			
15+1	30. Name and address of person	who completed caus	e of death (Item 2:	3a) (Type, F	Print)			•				
	Anushiravan Da				enter Dri	ve, Rock	ville,	Md. 208	350			
State Registrar	31. Date filed (Month, Day, Year	9 2006	egistrar's Signatur	So	de							

Regis DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 2006 **Physician** 12, KNIGHTON 12:16 AM CECIL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 24 Hrs. If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Min. 1**∑**M 2□F Hours Director Nov. 5, 1918 Maryland 214-05-1894 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or iteme 23a or 28e-f ehow Exacting must be notified at 1√Yes 2□No Completed by Funeral Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code death with 21401 United States 47 Southgate Ave. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of health and Merial Hygiene.
ante If Item 27 le marked other then "natural; or iten
any or other treumatic event, the Moulcal Exeminal 1 X Yes 2 □ No WWII If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Commercial Real Estate 2 Realtor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Cecil Brown Knighton Ida Bassford 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1339 Waterbury Rd. Crownsville, Maryland 21032 Laurence Knighton / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages I Department of H Importent: If ite eny Injury or ot once. 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 7/15/2006 Davidsonville, Maryland Davidsonville U/M Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Pervice Lic 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Mucha 147 Duke of Gloucester St. Annapolis, MD 21401 Approximate 23a. Part I. Enter the disease, or complications that caused the death, bo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) usinary tract infection Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy ŏ Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Meumonia 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number all welle 1757078 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and Ryan Parkway. lacqueline 2001 31. Date liled (Month, Day, State Registrar

State of Maryland / Department of Health and Mental Hygiene $_{\bigcirc}$ Amended item 1 - State #5, per/f.home, 7/25/06, E. Certificate of Death WCHD Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Elsie Alvarez Kelley 15 2006 6:55 P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ocean Pines
If Under 1 Year If Under 24 Hrs. Worcester Hidden Lake Ct. Birthplace (State or Foreign Country) 5 Social Security Number 217-44-0486 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2X F Yrs. 217-44-6486 85 Director 5/11/1921 Puerto Rico Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County or 28a-f show 1 Yes 2 XNo Directo Ocean Pines MD Worcester 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "naturel", or Items 23a or the Medical Examiner must be r 4 Hidden Lake Ct. 21811 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ≥ 2 TNo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1⊠Yes 2□No Specify: Puerto Rican Baltimore, Maryland 21215-0036 Specify: Hispanic þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Il Hygiene. Federal Government Chemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I Pages 1 and 2 should be ဂ္ Enrique Alvarez de Pagan Lola Alvarez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Item 27 to other tre Leonard B. Kelley (husband) 4 Hidden Lake Ct., Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If Ite any Injury or ot ang Injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 07/17/2006 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 3a. Part1. Enter the disease, or complication shock, or heart failure. List only one can 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Finat disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 SNo o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo မှ s efter death.
I Director: After this of in by the funeral di 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending 1 Tyes 2 No investigation 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours er Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and titte of certifier D0058410 30. Name and address of person who completed cause of death (Ilem 23a) (Type, Print) ARROLDWOOD CT. SALISBURY UD. 21801 10 GHYLAM WARIS 26266 31. Date filed (Month Cay, State Registrar

			For State Registrar	State o	f Marylan				lealth a Death	and M	lental Hyg	jiene Jeg. No.	00	6	243	301
	10 to 10 to		Decedent's Name (First, Middle, La	ast)							2. Date of Dea	th			3. Time of	Death
	Physici /Medio		Francine Lis	ser							Month July	14	200		6:20	A M
	Examin		4a. Facility Name (If not institution, gi	ve street and nu	mber)		4b. Cily	Town, or	Location o	of Death		4c. C	ounty of E	Death		
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45,7	Funeral		· ·	Sex 1 ⊡ M 2 🛣 F	7. Age (In yrs.		Months	Days	If Under:	Min.	8. Date of Birth (Month, Day	Year)	9.	Birthpla Countr	ice (State o.	r Forei g n
N. S.	Director		579-74-5862 Usual Residence of Decedent		50	110.					May 23,	195	6 1	wash	., DC	
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10	d. Inside Cit	y Limits
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	or 28	Director	10e. Street and Number				10f. Zi	p Code				l0g. Citize	n of What	t Counti	y?	
	ath w	rai	4453 B St.,						200						tates	
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itema 23e or 28e-f show ent, the Madical Examinar must be mailfied at	Funerai	11. Marital Status	Armed Fo		.S. 13.	Was Dece If Yes, spe	dent of H orfy Cuba	ispanic Orig in, Mexican	gin? (Sp , Puerto	ecify Yes or No- Rican, etc.)	14	. Race - A Black, V	Vhite, e	tc.	
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nd	d oth	Be	17. Father's Name (First, Middle, Las						18. Mothe	r's Nam	e (First, Middle,			_		
<u> </u>	Men Markenaric	2	Willie Le			401 14 11		10.					Danc			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23s or 28s-4 show apprintury or other traumatic event, the Madical Examiner must be notified at Once.		19a. Informant's Name/Relationship Michael T. Lise		Son		_				al Route Numbe Vash., D		0019	te, zip (:0 a e)	
<u>ق</u>	Heal Heal tem 2		20a. Method of Disposition		20b. F	Place of Dispo	osition (Na	me of	-				ation - City	or Tow	n, State	
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8760,	eath certificate be executed attending physician and for use as the burial-transit	dicai		d												
9		Medi	IE FEMALE.									-1				
Вох	th ce tendii	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 13 months?	23c. If yes, ou 1 ☐ Live b	tcome of pregna pirth 2 - Feta]Ectopic p	regnancy				23	d. Date of Month			'ear
o.	the at	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	4∏Pregr 9∏ Unkn	nant at time of d own	leath 5[Other (s	pecify)					WOITH		ay 1	ваг
О.	The law requires that the death certific ate has been signed by the attending F page 2 should be detached for use as		Part II. Other significant conditions	contributing to d	eath but not res	ulting in the u	ınderivina	cause oivi	en in Part I.		23e. Did to	bacco use	contribut	e to the	cause of de	eath?
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Division of Vital Records,	for At after of Direct S in by	Certification:	4 Homicide determined	4 286. Place	of Injury - At hing, etc. (Specif	ome, farm, st	reet, factor	y, office			28f. Location (S. City or Tow		Nu mbe r oi	r Rurali	Route Numi	oer,
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	(5)	N	30. Name and address of person who							-	MD 207		1			
K			Gary Lit	200	Conjetrarie Sign	Hospit		., C	never	ту,	MD 207	85				-
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			For State Registrar	State of	Marylan		artment of H			giene Reg. No:	006	24302
			1. Decedent's Name (First, Middle	, Last)					2. Date of De	aath Day	Year	3. Time of Death
	Physici /Medic		Patrick Alusi	ne Leen					07	12	06	11:40 P ^M
1	Examir		4a. Facility Name (If not institution	give street and num	nber)		4b. City, Town, or		ath		County of Death	
			Montgomery Hos				Rockvi				Montgom	
М	Funeral		5. Social Security Number	6. Sex 1 3 M 2 □ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, Da	ay, Year)		place (State or Foreign ntry)
	Director		100-72-3451 Usual Residence of Decedent		46	7101			08	17 59	Wes	t Africa
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Many Feat	tō	MD Prince	Georges	For	rt Wasi	nington					1 X Yes 2 ☐ No
	r 288	Director	10e. Street and Number	COLGEO			10f. Zip Code			10g. Citize	en of What Cou	ntry?
	th wit	ai D	13720 Pendlet	on Street			2074	14		Uni	ted Sta	tes
	ems ems	Funeral	11. Marital Status		dent Ever in U.	.S. 13.	Was Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	o- 14	4. Race - Ameri Black, White.	
98	or It	y Fu	1 ☐ Never Married 2 ☑ Marri	ed 1 ☐ Yes If Yes, Give	2 ⊋No e	i i	1 ☐ Yes 2 🗓 No	Specify:	,	s	Poncifu:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show ta Mailcal Ext. illiar i ual be indiffed at	d by	3 Widowed 4 Divorced	Year or Da	ites:	l 40- D					BT	ack
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Z	and 2 naith a n 27 i		Betty Leen			13720) Pendlet	on Stre	et, Fort	Washi	ington,	MD 20744
ore	of He fitan		20a. Method of Disposition 11 Burial 2 ☐ Cremation	3 Permoval from S		Place of Dispo emetery, crea	osition (Name of matory or other plac	(e)	Date	20c. Loca	ation - City or T	own, State
Ĕ	Pag ment ant: I ury o		'4 □ Donation 5 □ Other (S			surrect	tion Ceme	tery 07	-22-06	Clir	nton, M	D
Baltimore,	permit. Pages 1 and 2: Department of Health ar Important: If itam 27 Is any injury or other trau		21. Signature of Funeral Service	Consee Ha	Ale	22	2. Name and Addres	ss of Facility S	trickland			rvices, P.A
	100		23a. Part1. Enter the disease, or	complications that ca	aused the deat					•	150, 110	Approximate Interval Between
	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition			0						Onset and Death
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687	death certificate be executed e attending physician and d for use as the burial-transit	edicai		d								
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ğ	at the death by the atter stached for i	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregna	irth 2 🗌 Feta ant at time of d		JEctopic pregnancy ☐ Other (s <i>pecify)</i>	′			Month	Day Year
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Records,	aw Is b	Completed by							24a. Was		24b. Were auto	opsy findings available
æ	The ate h page	Com							perfo 1 ☐ Yes	ormed? 2X No	death?	2□ No
Vital	ysician: The is certificate director, pag	Be (25. Was case referred to medical examiner?				I a	-	Death (Check only	one)		
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U C	ling After Tune	lon	27. Manner of Death 1 ▼Natural 5 □ Pendin	9	h, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2∐No	28d. Describe	now injury	occurred	
isi	Attanding r death. actor: After y the fune	icat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be One Blace	of Injury - At ho	nme farm st	reet, factory, office	163 2 110	28f Location (Street and	Number or Run	al Route Number,
Division	after Dirac	Certification:	4 ☐ Homicide determ		ng, etc. (Specif		cet, factory, office		City or To	wn, State)		
	Hospital 24 hours a Funaral I tely filled	aic		g Physician: To the								
	To the Hospital or Attending Physinin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	(Check only 2 Medical one)	Examiner: On the ba and mann		tion and/or in	vestigation, in my o	pinion, death or	curred at the time,	date and p	lace, and due t	o the cause(s)
	To tha To tha complet	Σ	29b. Signature and Atle of certifie	0			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
	(3)) Kxl	1	_ N	D	D3	5635		Ju1	y 13, 2	2006
	Coin		30. Name and address of person	·			Print)					-
	AC.		Joseph Kaplan,	M.D. 6001	Muncas agistrar's Signa	ster M	ill, Rock	ville,	MD 20853			
	Sta Regist		JUL 1 7 2006	Blown)	agistrar's Signa	well.						

			For State	State of Marylar		rtment of I			giene Reg. No.2	006	24303
			Registrar Decedent's Name (First, Middle, La	st)			D Gat	2. Date of De.	ath	000	3. Time of Death
	Physicia /Medic		WILLIAM GARY	LEE, SR.				July	2) Day	200(0 17:35 M
	Examin		4a. Facility Name (If not institution, given	re street and number)		4b. City, Town,	or Location of Dea	th ₁	4c. Co	unty of Deat	
			5. Social Security Number 6.	Sex 7. Age (In yrs	(a at histh day)	If Under 1 Year	OCOUNT If Under 24 Hrs	8. Date of Bird	<i>A</i>		place (State or Foreign
Н	Funeral Director		220–28–9251	Sex 3 7. Age (In yrs 11X1 M 2□ F 73	Yrs.	Months Days			y, Year)	Co	ARYLAND
	ס		Usual Residence of Decedent		· · · ·						
	anylar •how	5	MD ALLEGA	_	ity, Town or Lo UMBERLA						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-f	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Co	ountry?
	within 72 hours after death with the Maryland ene. Then "natural" or Items 23a or 28a-f ehow he Madical Examinar must be notified at	DIE	14213 WALTER DE	RIVE		21502	2		U.S	.A.	
	deat	ner	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. V	Vas Decedent of f Yes, specify Cut	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No	- 14.	Race - Ame Black, White	rican Indian, e. etc.
36	s after	Completed by Funeral	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give		□Yes 2X No		,		acity:	VHITE
8 P	e hour	edb	15. Decedent's E	Year or Dates: 151-	16a Deced	lent's Usuaf Occu	pation		16b. Kind	of Business/	
215	thin 72 9. "nu Medi	ple	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) Coflege (1-4or 5+)			e during most of wo ed)				
7	filed wit Hygien other the	Con	12		AIR	CRAFT M	ECHANIC		U.S. A		RCE
Maryland 21215-0036	d be fill ed oth	Be	17. Father's Name (First, Middle, Las (UNKNOWN)	"				ame <i>(First, Middle,</i> RET LEE	Maiden Sui	mame)	
Z	should be I and Menta! I marked o umatic eve	P	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Stree	et and Number or F	Rural Route Numbe	er, City or To	οwπ, State, 2	Zip Code)
Ž	alth a 127 is ar trau		LAVINA LEE / W	IFE	14213	WALTER	DRIVE, C	UMBERLAN	ID, MD	2150	02
ore,	of He of He of He of Item	15	20a. Method of Disposition 1 □ Burial 2X Cremation 3 [Place of Dispo cemetery, cren	sition (Name of natory or other pla	ace)	Date	20c. Locat	ion - City or	Town, State
Ē	Pag tment tent: I	-	4 □Donation 5 □ Other (Special	w), CU			FORY 07/2	24/2006	CU	MBERLA	AND, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Department of Health and Mental Hygiens "natural", or Items 23a or 28a-f show many Injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Lice	Typchure	22	Name and Addr UPCHURCI 202 GREI	ress of Facility H FUNERAL ENE STREE	HOME, F	A. CRLAND	, MD	21502
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	aplications that caused the dea one cause on each line.	ath. Do not ente	er the mode of dy	ing, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Cardiomyopa							3 years
	/Medical Examiner		resulting in dealth)	Due to (or as a conse	queñce of):						o y cars
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence of):						
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С.							
ó,	ate be executed hysicien and he burial-transit		resulting in death) Last	Due to (or as a conse	quence of):						
	icate be executed physicien and s the burial-transit	Physician/Medical		d				<u> </u>			
9 X	certifi ding I	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr	nancy				23d	. Date of del	ivery
Box	es that the death certific igned by the attending p be detached for use as	iclar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of]Ectopic pregnand] Other (specify) _	cy			Month	Day Year
P.O.	at the by the	hys	9 Unknown	9□ Unknown							
Records, F	The law requires that the death certific sie hes been signed by the attending p page 2 should be detached for use as s	þ	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause g	iven in Part I.		obacco use Yes 2□N		o the cause of death?
eco	ie law requir hes been si ge 2 should l	Completed						24a. Was		4b. Were au	itopsy findings available completion of cause of
<u> </u>	The page	Com						perfo 1 ☐ Yes	rmed? 2/2/No	death?	
Vita	Physician: r this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2		_ 0	thor	eath (Check only o			
o	Phys or this oral di	To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	☐ ER/Outpatien 28b. Time of	3000	4 🗆 140131119	Home 5 Resident			cify)
ion	Attending r death. octor: Afte	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		ork? ⊒Yes 2∐No				
Division of Vital	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the tuneral director, page	Certification:	3 Suicide 6 Could not determined		home, farm, str	eet, factory, office	•	28f. Location (City or Tox		umber or Ru	ural Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled			hysician: To the best of my kr							
	To the Ho within 24 I To the Fu completel	ledical	one)	miner: On the basis of examir and manner stated.			•		•		. ,
	V With Con	Σ	29b. Signature and title of certifier	1		29c. Licer	ise number		Zed. Date s	igned (Monti	3. 2 (106)
5,	INA		30. Name and address of person who	completed cause of death (Its	am 23a) (Type	Print) -	6766		0./		71 - 000
5	nes		VILL POODZI, L	ND -9645	to Dr	Cen	berland.	RLB	2150	12	
	Sta	te ar	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature	20 M					h, Day, Year) 3, 2. UDG

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** July 2006 16, Legault 2:20A. M Louise /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Springhouse at Westwood Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Dec. 8, 1917 9. Birthplace (State or Foreign Bronx, New York **Funeral** Months Days Hours 1 ☐ M 27 F 88 013-22-0214 Yrs. Director Usual Residence of Decedent be filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ul Hygiene, other then "naturel", or lieme 23a or 28a-f ehow vent, the Medical Examinar must be notified at Chevy Chase 1 ☐ Yes 2 No Maryland Montgomery **Funeral Directo** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4515 Willard Avenue, #2115 South 20815 United States 12. Was Decedent Ever in U.S. Agned Forces?

12 Yes 2 No
If Yes, Give
Year or Dates: unk. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify. Completed by 3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 Hospital Registered Nurse event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if them 27 is marked oth eny injury another treumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Max Munishor Rebecca Aronowitz ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 87 Clinton Street, #17 New York, New York 10002 Robert Legault -son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 7/18/2006 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Cardiovascular Accident fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ą 3 ☐ Probably 4 X Unknown Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No certificate 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{\text{Other}} \) Other (Specify) 1 ☐ Yes 2 XNo Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funerei Director: After the completely filled in by the funeral 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours at To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) D48043 July 18, 2006 naron 30. Name and address of person who completed cau. Sharon Ann Scanlon, M.D. of death (Item 23a) (Type, Print) 5530 Wisconsin Avenue,#1400 Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year) JUL 19 2006 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink John Joseph Loessel State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month **Medical Examiner** 1658 hrs John Joseph Loessel, Sr. July 16, 2006 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** oreign Maryland Director Months Days Hours Min Jul 13, 1946 220-46-6669 1X M 2 F 60 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Carroll Finksburg 28a-f show Maryland 1 Yes 2 X No cattimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene
Important: If item 27 is marked other than ".....
injury or other traumatic...... 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21048 USA 2104 Ridgemont Drive 莅 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, 8lack, Armed Forces? White, etc. 1 Never Married 2 Married 1 X Yes white If Yes, Give Yeal 966-1967 1 Yes 2 X No specify Widowed 4 Divorced Specify þ or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electric Company Electrician 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Allen Ludger P. Loessel Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda J. Loessel, wife P.O. Box 1333, Hanover, PA 17331 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 7/21/2006 Finksburg, MD Evergreen Memorial Donation 5 Other Specify: 22. Name and Address of Facility Signature of Funeral Service Licensee M01191 Myers-Durboraw Funeral Home Willis Street, Westminster, MD 21157 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** ailure. List only one cause on each line. Between Onset and /Medical a. Atherosclerotic cardiovascular disease complicated by hyperthermia Death ediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit UNPENDED AMENDED

Fetal death

Other (Specify)

2

5

1430 hrs

3 Ectopic pregnancy

26 Place of Death (Check only one)

Other₄

Yes 2 V No

28c. Injury at Work?

29c, License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

DOA

23d. Date of delivery

23e Did tobacco use contribute to the cause of death?

24a Was an autopsy

Nursing Home 5 Residence 6

temperatures

performed? ✓ Yes 2 No

28d. Describe how injury occurred

1 Yes 2 No 3 Probably 4 V Unknown

death?

Subject exposed to extreme environmental

or Town, State) 937 Old Wesminster Pike, Westminster, MD

July 17, 2006

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

1 🗸 Yes

24b. Were autopsy findings available

prior to completion of cause of

Year

2 No

tending physician a use as the burial signed by the attending page 2 should peen certificate has this

Division of Vital Records, P.O. Box 68760, Fo the Hospital or Attending Physician: death. the Director:

within 2 To the I MJL 3+IVA

> State Registra

3

Suicide

Homicide 29a Certifier

Pamela Southall, MD

31. Date filed (Month, Day, Year)

Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Chronic ethanolism Completed 25. Was case referred to medical Be examiner? Hospital: Inpatient 2 V ER/Outpatient 3 1 V Yes Manner of Death 28b. Time of Injury 1 FOUND:

28a. Date of Injury FOUND: Day, Year) Natural 5 Pending Jul 16, 2006 2 🗸 Accident

Investigation 6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. determined

(Specify) Single Family Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

Registrar's Signature

ORIGINAL

			State of Maryland / Department of Health and M 1 - State Registrar Certificate of Death		iene eg. No.200	6 24306
			Decedent's Name (First, Middle, Last)	2. Date of Deat	h	3. Time of Death
п	Physicia /Medic		JAMES E. LANDON	Month JULY 1	Day Yea 4.2006	11:45P M
)	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of D	
			HERITAGE HARBOUR HEALTH & REHAB, ANNAPOLIS		ANNE AR	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Yrs. 7. Age (In yrs. last birthday) Yrs. 1. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
ш			216 16 5145 X 81 11S. Usual Residence of Decedent	SEPT.17	, 1924 MA	RYLAND
	arylan show	<u>.</u>	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	death with the Maryland ims 23a or 28a-f show if its latt be notified at	Director	MARYLAND ANNE ARUNDEL ANNAPOLIS		0.00	1 ☐ Yes 2√∑No
	with t	ä	10e. Street and Number 10f. Zip Code		0g. Citizen of What	ŕ
	Jeath ns 23	Funerai	929 BARRACUDA COVE COURT 21409 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	UNITED ST	MIES merican Indian,
9	or Iter		1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Ma	Rican, etc.)	Black, W	hite, etc.
ဗ္ဗ	urel', c	d by	3 Wildowed 4 □ Divorced If Ves. Give Year or Dates:		Specify: W.	HITE
21215-0036	"natu	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work) [ife. DO NOT use retired]	ing	16b. Kind of Busine	ss/Industry
212	iene.	ошь	Elementary/Secondary (0-12) College (1-4or 5+) 10 0 SUPERVISOR		UTILITY_C	OMDANTV
	e filed of hyg other	4	17. Father's Name (First, Middle, Last) 18. Mother's Name			MIFANI
<u>Ja</u>	Menta Menta arked	To B	ALBERT LANDON MARY M.	BOYD		
Maryland	2 should and 10 mm		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	al Route Number	, City or Town, State	e, Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 ie marked other then "naturel", or Items 23a or 28a-f show eny injury or other traumatic event, it a Medical Examination matter to an other traumatic event.		20a Method of Disposition 20b, Place of Disposition (Name of		IS, MD. 21.	
Baltimore,	ages ant of it: If it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery, crematory or other place			
Ħ	nit. Poertme cortan injur		4 Donation 5 Other (Specify) MARYLAND VETERANS CEM 07-19 21. Signature of Eugen Service Cleensee 22. Name and Address of Facility GEO	DCF D 1	CROWNSVIL	LE MD.
ă	Depe Impo eny i		2973 SOLOMONS ISLAN			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c shock, or heart failure. List only one cause on each line.		est,	Approximate Interval Between
20	Physician		Immediate Cause (Final disease or condition resulting in death) a. Coruma green disease of):	e		Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
Ö,	cate be executed physician and the burial-transit	Ex	resulting in death) Last Due to (or as a consequence of):			
8760,	cate b physic the b	dical	d			
9 X	ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of	dolivona
Вох	es that the death certific igned by the attending p be detached for use as	Physician/Med	in the past 12 months? 1		Month Month	Day Year
Ö.	the che	hysi	9 ☐ Unknown	,		
s, P	The law requires that ate has been signed b page 2 should be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
ord	w requir been si should			1 □ Ye	s 2 □ No 3 □	Probably 4-Unknown
Sec.	e taw has b	Completed		24a. Was a autops perform	y prior t	autopsy findings available to completion of cause of
alF	ician: Th certificate rector, pag			1 ☐ Yes 2	2 No 1 □ Y	
₹	Physician: rthis certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		e) ince 6 □Other (S	paciful)
1 0	g Phy er this neral c		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		w injury occurred	респу
ioi	Attending F r death. ector: After by the funer.	atio	2 Accident investigation M 1 Yes 2 No			
Division of Vital Records,	or Attendated after deatler deatler blrector:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town		Rural Route Number,
	pital o		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the co		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a consistency of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a consistency of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a consistency of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a consistency of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a consistency of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a consistency of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a consistency of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a consistency of the basis of examination and/or investigation, in my opinion, death occurred at the consistency of the basis of examination and/or investigation, in my opinion, death occurred at the consistency of the basis of examination and/or investigation, in my opinion, death occurred at the consistency of the basis of examination and or investigation and occurred at the consistency of the consis	ed at the time, da	ate and place, and o	as stated. lue to the cause(s)
	To the within 2. To the I complet	Me	29b. Signature and title of confifier 29c. License number	2	9d. Date signed (Mo	onth, Day, Year)
			> Mad 1 1 2 1 8 1 9		July 1	6,2006
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mctthcw 5 Melt 132 Itulion CT Juite	201 1		
	Sta Registr		31. Date filed (Month, Day, Year) JUL 18 2006 32. Fegistrar's Signature			

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 450 A 2006 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner nnapolis les 1(a en. runde II Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Min 1□ M 2DXF N Director N -16-2006 lance Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director JENGRN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 101 9 0 Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify þ 3 Widowed 4 Divorced lack Year or Dates: "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) D es 1 and 2 should be filed wolf Health and Mental Hygie filem 27 is marked other t 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ar e/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 1705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2X Cremation 3 Pemoval from State Metro Crematory 7-27-2006 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Sen once. Hardesty Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Heme resulting in death) /Medical Due to (or as a consequence of) Examiner Over whe Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. peq. ð Division of Vital Records. 1 Tes 2 🕅 No 3 ☐ Probably 4 ☐Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 Yes 2 No 1 Yes 2 No Physician: rector, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner' Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 0 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, ay Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After or Attending 1 Natural 5 Pendina F 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At hon building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) At home, larm, street, factory, office 4 Homicide To the Hospital 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) o completed cause of death (Item 23a) (Type, Print) 30. Name and does person 31. Date filed (Month, Day, Year) 32. Begistrar's Signature Registrar 2006

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryla		artment of H rtificate of L			gienez 0 0 6	24308
	Physici		1. Decedent's Name (First, Middle, Las TAWANA ELAII	•				2. Date of De. Month JULY	Day Year 26, 2006	3. Time of Death 8:52AM ^M
	/Medic Examir		4a. Facility Name (If not institution, give				Location of Death		4c. County of Dea	ith
	Funeral Director		2965 MARSH HAWI 5. Social Security Number 6. Social Security Number 1		. last birthday) Yrs.	WALDO If Under 1 Year Months Days	RF If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year) C	LES httplace (State or Foreign ountry) ENTUCKY
prison	>2%		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation		110111		10d. Inside City Limits
the Mar	28a-f show	rector	MARYLAND CHAR 10e. Street and Number	RLES	WA	LDORF			10g. Citizen of What C	1 ☐ Yes 2∰No ountry?
diw di	23a or wat be	ai Di	2965 MARSH HAWE	CDRIVE		206	03		U.S.A.	
5-0036	"natural", or Items 23a or 28a-f shov	by Funeral Director	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 No Hayes, Give Year or Dates:	1	Was Decedent of Hi if Yes, specify Cuba 1 ☐ Yes 2X No		pecify Yes or No Rican, etc.)	Specific	
2	- 35	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	turina most of won	king	16b. Kind of Business	Industry
N z	Hygie other t		12. 17. Father's Name (First, Middle, Last)	4	HC	MEMAKER	18. Mother's Nam	ne (First, Middle,	— OWN HC Maiden Sumame)	ME.
ylan	marked other them	To Be	JOSEPH MICKERI	DE MOSS			ZELMA	MAE UT	LEY	
Maryland	. 70 00 2		19a. Informant's Name/Relationship (7DAVID A. MIMS-H	•		-			er, City or Town, State, ALDORF, MA	20603
Baltimore,			20a. Method of Disposition 1 **Disposition 1 **Disposition 2 **Disposition 3 **Disposition 5	20b. Removal from State	Place of Dispo cemetery, crea	sition (Name of matory or other place	θ)	Date	20c. Location - City of	Town, State
Baltin	Department of Important: If any injury or once.		21. Signature of Funeral Service Licen	see / M004	478	RAYMOND	s of Facility	I. SERV	TCF D A	MARYLAND
	hysician /Medical		23a. Fart1. Enter the disease, or compshook, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. CANCER	-01 A	er the mode of dying	g, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
3760, <-	xaminer and the purial-transit	licai Examiner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.)	quence of):		loo dolla dalla anno anno Palano			
Box 6	nding I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ords, P.O	been signed by the atte	b	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause give	en in Part I.		obacco use contribute to	o the cause of death?
I Rec	ate has	Completed							osy prior to rmed? death?	utopsy findings available completion of cause of
of Vital	certific	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	750/0	3C DOA Othe	26. Place of Dea			
on of	After fune	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	28c. Injury Work	4 🗆 Ivuising 🗔	-	dence 6 Other (Spenow injury occurred	icity)
Division	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, sti lify)	eet, factory, office		28f. Location (5 City or Ton	Street and Number or R vn, State)	ural Route Number,
E S	within 24 hours after d To tha Funeral Dirac completely filled in by	edical		ysician: To the best of my kn liner: On the basis of examin and manner stated.						
	within To th comp	Me	29b. Signature and title of certifier	WOIL	M	29c. License	2062	9	29d. Date signed (Mont	1h. Day Year)
*	10		30. Name and address of derson who	completed cause of death (Ite	om 23a) (Typa	Print) WE	D. O. V	25. 4	Md. 20	603
	Sta Regist	. 2	31. Date filed (Month, Day, Year)	32. Segistrar's Sign	lature	rocks				,

		-	For State Registrar	te of Marylan		artment of H			iene g. No. 006	24309
	Physici		Decedent's Name (First, Middle, Last)		16			2. Date of Death Month		3. Time of Death
	/Medic	al -	Frank	W.	McI	Lhenny		July	30 2006	
	Examin	er	4a. Fecility Name (If not institution, give street as			4b. City, Town, or	Location of Death		4c. County of De	ath
			SunBridge Care Cente 5. Social Security Number 6. Sex	7. Age (In yrs. i	last birthday)	Elkton If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Cecil 9. B	rthplace (State or Foreign
н	Funeral Director		207-16-4007 1 ^M ²⁰	7	Yrs.	Months Days	Hours Min.	June 16, 1	Year) (nnsylvania
	D		Usual Residence of Decedent 10a, State 10b, County	10c Cib	y. Town or Lo					10d. Inside City Limits
	faryla show	٥	Maryland Cecil		arlevi					1 ☐ Yes 2 No
	28a-1	Director	10e. Street and Number	Lie	111611	10f. Zip Code		10	ng. Citizen of What (country?
	h with	D	5 Cecil Road			21919			United St	ates
	ams 2	Funeral	11. Marital Status 12. Was	Decedent Ever in U.	S. 13. 1	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n. Mexican, Puerto	pecify Yes or No-	14. Race - An Black, Wh	
36	72 hours after death with the Maryland natural; or itams 23a or 28a-f show steat Evanther manke molified at	by Fu	1 Never Married 2 Married 1 M	Yes 2 No Was		1 ☐ Yes 2 📉 No	Specify:			hite
Ö	hour		15. Decedent's Education	r or Dates:	16a, Dece	dent's Usual Occupa	ation	1	16b. Kind of Busines	
215	in 72 In "na Medic	piet	(Specify only highest grade compl	eted) ege (1-4or 5+)	(Give life.	kind of work done of DO NOT use retired	luring most of worl)	king		,
21	filed within Hygiene. sthar than "	Completed	12	090 (7 101017	Pa	ster			Publish	ing
Maryland 21215-0036	be filed within 72 hours after death with the Marylan tal Hygiene. ad other than "natural; or items 23a or 28a-1 show or other than "natural; for modified at	Be	17. Father's Name (First, Middle, Last) Frank McIlhenny				18. Mother's Nam Eliza	e (First, Middle, M	faiden Sumame)	
ryla	2 should be f and Mental H is marked of raumatic eve	ဥ	19a. Informant's Name/Relationship (Type, Prin	**	10h Mailir	o Address (Street			City or Town, State	Zin Code)
Ma	D = V =		Doris B. McIlhenny/Wi						1and 2191	
ē,	s 1 and 2 f Health item 27 othar tr	1	20a. Method of Disposition	20b. P	_	sition (Name of natory or other place		The second second second second	West Ches	
E	Page nent o nnt: if ury or		1 ☐ Burial 2 X Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State		s & Co., In		,	Pennsylva:	nia
Baltimore,	permit. Pages 1 an Department of Heali important: if item 2 any injury or othar 2008.		21. Signatule of Funeral Service Licensee	turs	H ²²	Name and Address ICKS Home 03 W. Sto	for Function Str	erals, P. reet, Elk	A. ton, Mary	land 21921
Vital Records, P.O. Box 68760,	Physician: The law requires that the death certificate be executed The partition of the law required by the attending physician and the properties of the properties of the page 2 should be detached for use as the burial-fransit or the page 2.	o Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 Do	ue to (or as a conseque . It is to birth 2 Feta Pregnant at time of d Unknown	uence of): uence of): uence of): incy i death 3 [eath 5 [Oth	an in Part I. 26. Place of Dea	1 Ye 24a. Was ar autops; perform 1 Yes 2	24b. Were prior to death?	Day Year to the cause of death? Probably 4 Junknown autopsy findings available ocompletion of cause of
of	Phye this ral dii	 	1 Yes 2 No	Date of Injury	ER/Outpatier 28b. Time o	IT 3LIDOA	4 Nursing H	ome 5 Reside 28d. Describe ho		ecify)
ion	Attending For death. sector: After by the funer	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		<br Yes 2 □No			
Division	ai or Attendi safter death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At he building, etc. (Specif	ome, farm, str	reet, factory, office		28f. Location (Str City or Town	reet and Number or i , State)	Rural Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funaral Director: completely-filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Exeminer: Or and	To the best of my known the basis of examina dimanner stated.	wledge, deat tion and/or in	vestigation, in my op	oinion, death occu	rred at the time, da	ate and place, and d	e to the cause(s)
)	NA With Com	Σ		lev-S. 1			023322	2	7.3/.	2006
	67,		30. Name and address of person who complete S . S S A C $HDEV$ M	d cause of death (Iten	n 23a) (Type, odt St	- Suite	3B,	Elktor	n MD 21	921.
	Sta Regist	_	31. Date filed (Month, Day, Year) AUG 0 2 2006	32. Pagistrar's Signa	J. P.	parke				

	7	1	For Stata Registrar	State of Man	•	partment of ertificate of			Reg. No.	006 243	310
77	Physicia	an	Decedent's Name (First, Middle, La: Mana	st) aret Blinco	o M:11o	~		2. Date of Month	Day	Year 2006 19,1L	
	/Medic Examin	Code I	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town,		JULY of Death		nty of Death	1
			UNION HOSTITA	. ,	IL COUNT	,		O.4 Line T		CIL	
	Funeral Director		402-22-5732	ex	In yrs. last birthda Yrs	Months Day	s Hours	Min. (Month.	Birth Day, Year) 6, 1909	9. Birthplace (State or Country) Kentucky	Foreign
	yland Now		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or	Location				10d. Inside City	y Limits
	should be filled within 72 hours atter death with the Maryland do Manual Hygiene. Tracked other then "netural" or iteme 23a or 28a-f ehow marked other then "netural" or iteme 23a or 28a-f ehow unatic event, tra Madical Examirar inval ke incitified at	cto	Maryland Cecil		E1kton					1 🗆 Yes	2 ሺ No
	vith th	Directo	10e. Street and Number			10f. Zip Code				of What Country?	
	eath v	Funeral	209 Woodholme Wa	12. Was Decedent Eve	er in U.S. 1	3. Was Decedent of	f Hispanic Ori	gin? (Specify Yes or	No- 14. R	ted States Race - American Indian,	
ထ	after d	Fun	1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2 🕅 No		If Yes, specify Cu	ıban, Mexican	, Puerto Rican, etc.)	В	Black, White, etc.	
000	ural', c	d by	3 X Widowed 4 □ Divorced	If Yes, Give "Year or Dates:					Spe	White	
<u>7</u>	in 72 h	olete	15. Decedent's Ed (Specify only highest gra	ide completed)	(G	icedent's Usual Occ ive kind of work don e. DO NOT use reti	e during mos	t of working	16b. Kind of	Business/Industry	
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Maryland 21215-0036	ould be filed v Mental Hygis Marked other Natic event, It	Be	17. Father's Name (First, Middle, Last,					r's Name (First, Mid		ame)	
Z	should ind Men marke umatic	٦ و	Joseph V. Blinco		19h M	ailion Address /Stre		ry M. Cash or or Rumal Route Nu		wn State Zin Codel	
	and 2 sl ealth and th 27 le r		Martin H.C. Mill			_		Elkton, N			
altimore,	of Head		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □			sposition (Name of crematory or other p		July 28,		on - City or Town, State	
E	Pages ment of I ant: If its lury or o		4 ☐ Donation 5 ☐ Other (Specif	y)	Cathedr	al Cemete	ry	2006		ngton, Delawa	are
Bail	permit. Pages 1 and 2 should Department of Health and Men Importent: If them 27 le marke eny injury or other traumatic.		21. Signature of Funeral Service Licer	8. Hick		Hicks Hom 103 W. St	fress of Facilit e for ockton	Funerals, Street, I	P.A. Elkton, I	Maryland 2192	21
~ ~	3		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.			ying, such as	cardiac or respirator	y arrest,	Approximate Interval Betw Onset and De	reen
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	1SCHEN		OWEL				Onsor and o	
	Examiner			Due to (or as a c		PNEU	noNI	A			
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c		, , , , , ,	- , , ,	• 1			
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o.	that the desired by the a	Physician/Med	1 Yes 2 No 9 Unknown	4□Pregnant at tin 9□ Unknown	ne of death	5 Other (specify)					
۵.	ne law requires that the death certificate be executed has been signed by the attending physician end ge 2 should be detached for use as the burial-transit	by Ph	Part II. Dther significant conditions	contributing to death but r	1	1 2	given in Part I	23e. D	id tobacco use co	ontribute to the cause of de	ath?
ord	w require been sig should b	ted	ATN, CAP	, +112 NUN	ners de	menha		1	☐ Yes 2 ☐ No	3 Probably 4 Dur	Tknown
Division of Vital Records,	has be	Completed						24a. W	As an 241 utopsy erformed?	b. Were autopsy findings a prior to completion of cal death?	vailable use of
a	certificate		25. Was case referred to medical				OC Pleas	1 ☐ Ye	s 2 100	1 Yes 2 No	
\equiv	Physician: The this certificate ral director, pag	To Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpa	tient 3 DOA)thes	rsing Home 5 R		Other (Specify)	
0 =	ding Phys I. After this funeral di	L :uo	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	'ear) 28b. Tim				be how injury occ		
20	tendidath. for: A the fu	icati	2 Accident investigatio	B Oos Disease de laive	At home form		Yes 2		n (Stroot and Mu	mber or Rural Route Numb	
<u>N</u>	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	4 Homicide determined	building, etc. ((Specify)	•		City or	Town, State)		θ/,
	Mospital 24 hours Funeral etely filled	Medical	29a. Certifier 1 Certifying Pl	nysician: To the best of a	xamination and/o	eath occurred at the	time, date an	d place, and due to t th occurred at the tir	the cause(s) and ne, date and plac	manner as stated. ce, and due to the cause(s)	
	# <u>5</u> # 6	0	one)	and manner state	u.						
)	To the within 2 To the complet	Me	29b. Signature and title of certilier	and manner state	u .	29c. Lice	ense number	1181		ned (Month, Day, Year)	
	To the vithin:	Me	29b. Signature and title of confier	and manner state		29c. Lice	ense number	486	JULY,	27 2000	
•	To the within To the comple	Me	29b. Signature and title of confier	and manner state M > completed cause of dea UNION		29c. Lice	onse number		JULY,		

			for Amend item#10e,17	State of Maryland / , perfil, 0858, 8/15/00	Depa	artment of Hertificate of D	ealth and leath	Mental Hyç	giene, Neg. No.	2006	24311
	Physicia		1. Decedent's Name (First, Middle, Last) Zebunnisa	Fateulla	1	Mogul		2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al -				Mogul		7/ 17		2006	10:30a M
	Examin	er	4a. Facility Name (If not institution, give s Shady Grove Ho			4b. City, Town, or l Rockvi		n		County of Death	
			5. Social Security Number 6. Sex		nieth day)		If Under 24 Hrs	8. Date of Birt		ontgom	
H	Funeral Director	+		M 20XF 80	Yrs.	Months Days	Hours Min.	(Month, Da)	, Year)		place (State or Foreign ntry)
			Usual Residence of Decedent					7/15/	1920	Ind	la
	/land		10a. State 10b. County	10c. City, To							10d, Inside City Limits
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	h the	lre	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	intry?
	th will	alD	12421 Falcon I	Bridge Dr.		20878	I		Ind	ia	
36	permit. Pages I and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "naturel", or Iteme 23e or 28e-f ehow any njury or other traumatic event, the Medical Examinal must be notified at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	'	Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 🛭 No	panic Origin? (S , Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		4. Race - Ameri Black, White, Specify: AS	
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77	iene.	E O	Elementary/Secondary (0-12) 4	College (1-4or 5+)	hou	sewife			ho	me	
	illed Hygi other		17. Father's Name (First, Middle, Last)	Abdul Gafoor Shaik	1			me (First, Middle,		_	
a	fental fental rked c	To Be	Gafoor Shai	kh-		1	Amirbi	S	haik	h	
Maryland	should and Men marke umatic		19a. Informant's Name/Relationship (Type	pe, Print) 19	9b. Mailir	ng Address (Street ar	nd Number or R	ural Route Numbe	r, City or	Town, State, Zi	p Code)
	and 2 saith a n 27 is		Shamim Shaik	h/daughter ´	1242	21 Falcor	n Bride	ge, Gai	ther	sburg	, Md.20878
altimore,	of He		20a. Method of Disposition 1	come	of Dispo	sition (Name of natory or other place)	Date	20c. Loc	ation - City or T	own, Slate
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att	permit. Departr Importa any nit		21. Signature Funeral Service Licanse	1/		. Name and Address					
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8760,	death certificate be executed Wedical Be attending physicien and office use as the burial-transit	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence). Due to (or as a consequence). Due to (or as a consequence).	e of):	portis	Ful	Dis	es.	f C	nset and Death
687	ificate g phy as the	edic		1.							
P.O. Box		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)			2:	3d. Date of deliv Month	very Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Dther significant conditions con	ntributing to death but not resulting	j in the u	nderlying cause giver	n in Part I.		bacco us ′es 2□		the cause of death? bably 4 Unknown
of Vital Records,	The ete h page	Completed						24a. Was autop perfor 1 \(\text{Yes} \)	sy	24b. Were aut prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of
/ita	icien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?					ath (Check only o	ne)		
ion of \	ing Phys After this uneral di	atlon: To	1 Yes 2 No 27. Manner Death Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 DER/C 28a. Date of Injury (Month, Day Year)	Outpatier Time of Injury	f 28c. Injury Work	4 (14013111g	Home 5 ☐ Resid			(fy)
Division	al or Attend after death I Director: d	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office		28f. Location (S City or Tox	treet and m, State)	Number or Rui	ral Route Number,
	n 24 hours a n 24 hours a ne Funerel I	ledical (29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	lge, deat and/or in	h occurred at the time vestigation, in my opi	a, date and place nion, death occ	e, and due to the curred at the time,	cause(s) a	and manner as a	stated. to the cause(s)
)	To the within 2 To the complete	Ň	29b. Signature and title of certifier	Dool 1	M	29c. License	number 2	61	Jul Date	signed (Month)	2006
R	(3)		30. Name and address of person who co	,				_ ,		//	00056
	Sta	te.	William Dooley, 31. Date filed (Month, Day, Year)	■2. Registrar's Signature		ical Cent	cer Dr	. Rockv	тте	, Md.	20850
	Regist		JUL 1 9 2006	Blede #	Good	W					

		4	For State	State of Maryl		artment of I		nd Mental		4000	24312
			Registrar 1. Decedent's Name (First, Middle, La	st)		timouto or	Dodin	2. Date			3. Time of Death
П	Physicia		Thelma Iola	Moses				Monti	v 7.	ay Year 2006	10:20A ^M
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town,	or Location of			c. County of Dea	th
	LAdimir	٠.	655 W. Mount I	ubentia Co	urt	Upper 1	Marlbo	oro	P	rince (Georges
	Funeral		Social Security Number 6. S		yrs. last birthday)	If Under 1 Year Months Days		Min. 8. Date	of Birth h, Day, Yea	9. Bir	thplace (State or Foreign ountry)
h	Director		249-40-3914	☐ M 2[X]F	76 Yrs.	Working Days	1.00.0		27,1		SC″
	and w	-	Usual Residence of Decedent 10a, State 10b, County	10c.	. City, Town or Lo	cation					10d. Inside City Limits
	Aaryta f eho	ö				Marlbor	_				1X Yes 2 No
	28a-	Director	MD . PG		opper i	10f. Zip Code	<u> </u>		10g. C	itizen of What C	ountry?
	Sa or	۵		Lubentia Co	nırt	207	72			ited S	
	me 2;	Funerai	11. Marital Status	12. Was Decedent Ever i	n U.S. 13.1	Was Decedent of	Hispanic Origi	n? (Specify Yes	or No-	14. Race - Ame	encan Indian,
9	or ite	필	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		If Yes, specify Cub 1 ☐ Yes 2 2 No		Puerto Hican, etc	;.)	Black, Whi	
21215-0036	filed within 72 hours after deeth with the Maryland Hygiene. other then "naturel", or Iteme 23a or 28a-f ehow ent, the Medical Examinar must be notified at	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:		10 103 212110	эрвспу.			Specify: Bla	ack
2-	natu	Completed	15. Decedent's E (Specify only highest gra		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of	of working	16b.	Kind of Business	/Industry
2	within	m m	Elementary/Secondary (0-12)	College (1-4or 5+)			(O)			Carraman	ant
N D	Hygie ther nt,		17. Father's Name (First, Middle, Last)	<u> </u>	lerical	18. Mother	s Name (First, M		Governn on Sumame)	llen c
Maryland	d be and a company of the company of	o Be	Rev. John M. A		r			la Ande		,	
<u> </u>	Should Me	ဥ	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Stree	and Number	or Rural Route N	lumber, City	or Town, State,	Zip Code)
Σ	nd 2 in the ar 27 io		Rev. Wanda Sis	co/daughte	9200 r Unne) Live (er Marl	Oak La	ane MD. 20	772		
Ē,	s 1 a of Hea Item othe		20a. Method of Disposition	20	b. Place of Dispo	sition (Name of matory or other pla		Date	-	Location - City or	Town, State
Ë	Page nent c int: if		1 Surial 2 Cremation 3 ⊆ 4 Donation 5 Other (Specil	Removal from State (y)		ction C		/15/06	C1.	inton,	MD.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 ie marked other then "naturel; or Iteme 23a or 28a-f ehow entry or other traumatic event, the Medical Examiner must be notified at ODGs.		21. Signature of Funeral Service Licer	isee		2. Name and Addr					
	40.204	\mathbb{H}	23a. Part 1. Enter the disease, or com	plications that caused the o						itland,	MD.20746
Н			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.					,,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Endometr Due to (or as a con		ncer					
	Examiner				isaquarica or).						
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	cuted nd ransi	Examiner	that initiated events	c							
Ö,	The law requires thet the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Ä	resulting in death) Last	Due to (or as a con	sequence of):						
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9	ertific ding p	We	IF FEMALE:	23c. If yes, outcome of pre	anana.						
Вох	thet the death certifica ed by the attending pt detached for use as t	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 □ Live birth 2 □ I 4 □ Pregnant at time	Fetal death 3	Ectopic pregnand Other (specify)	У			23d. Date of de Month	Day Year
o.	the de	yslc	1 ☐ Yes 2 ᠓ No 9 ☐ Unknown	9□ Unknown	or death 5	_ Ottler (specify) _			_		
0	res thet igned by be deta	4 4	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause g	ven in Part I.	23e.	Did tobacco	use contribute t	o the cause of death?
rds	quires n sign								1 🗌 Yes	2 ⊠ No 3□P	robably 4 Unknown
Ö	w requir	lete							Was an	24b. Were a	utopsy findings available
Be	The lavie has	Completed							autopsy performed?	death?	completion of cause of
tal		0	25. Was case reterred to medical				26. Place o	of Death (Check	res 2⊠N onlv one)	10 1010	220 190
\geq	o o	ToB	examiner? 1 ☐ Yes 2 XNo	Hospital:	2 ER/Outpatier	nt 3 DOA		sing Home 5 🔀		6 □Other (Spe	ecify)
0	Attending Physician: r death. ector: After this certific by the funeral director,		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	z8b. Time o					ury occurred	
<u>S</u>	ttendir death. ctor: Al / the fu	catic	2 Accident investigatio			M 1]Yes 2□N	0			
Division of Vital Records,	or Att	Certification;	3 Suicide 6 Could not be determined		At home, farm, str pecify)	eet, factory, office			ion (Street a or Town, Sta		ural Route Number,
	Hoepital or 24 hours afte Funaral Dir tely filled in I		29a. Certifier 1 XCertifying PI	nysician: To the best of my	knowledge deati	h occurred at the t	me date and	place, and due to	the cause/	s) and manner a	s stated
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After thi completely filled in by the funeral.	edical		miner: On the basis of examiner stated.							
	To the within 2 To the complet	Σ	29b. Signature and Vitle of certifier	les			se number			ate signed (Mon.	
)	C		· VS	week-		D291	42		Jul	y 14,	2006
	Gard S		30. Name and address of person who Dr. Charles Be	completed cause of death			. Was	hinator	ı. DC	2001)
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S			,		-1 00	2001	<u> </u>
	Regist	ar	JUL 1 7 2006	were the	your !						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 18:15 M Miller Jean 07 Norma /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WMHS-Campus Cumberland Allegany Braddock If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗓 F 216-30-1707 Director 11/04/1933 Marvland Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show r than "natural", or Items 23a or 28a-f sho the Medical Examinar must be rutified at 1 Yes 2 □ No Allegany Cumberland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 517 Furnace Street USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Social Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event 2008: Be Hansrote Barnes Pearl Beatrice 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Route 2 Box 462, Ridgeley, WV 26753 Cyndi Snyder / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 07/23/2006 Cumberland, MD 4 ☐Donation 3 ☐ Other (Specify) Zion Memorial Park 21. Signatur of Fureral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. alla 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION FOUR HOURS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last signed by the attending physicien and does detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 WNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown RENAL INSUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PNEUMUNIA autopsy performed certificate 1 ☐ Yes 20 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of D33417 (CHARTUMD) JULY 21, 2006 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MON 21502 1068 NATIONAL HIGHWAY LAVALE, MARYLAND JAMES R. MOEN, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's aignature State Registrar

ORIGINAL

			State	of Maryland / [_	- 1 - 1 - 1
			For State Registrar	•		tificate of L			Reg. No	211116	24314
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of E Month	eath Da	y Yea	
	/Medic	cal	Margaret Rose Mod 4a. Facility Name (If not institution, give street and			4b. City, Town, or	Location of	July	15	200 County of De	
	Examir	ner	Long View Nursing			Manche		Death		arrol	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bir.		If Under 1 Year Months Days		Min. (Month, L	irth Day, Year)	9. E	Birthplace (State or Foreign Country)
	Director		215-28-8310 Usual Residence of Decedent	F 87	Yrs.			03-0	3-19	019 M	Maryland
	yland now		10a. State 10b. County	10c. City, Town	n or Lo	cation					10d. Inside City Limits
	a-fsk	ctor	MD Carroll	Ham	ps	tead					1 ☐ Yes 2√2 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Marical Examitter traumatic event, it is Marical Examitter to unit by notified at	Completed by Funeral Director	10e Street and Number 4019 Evergreen Dri	ve		10f. Zip Code	074		10g. Cit	izen of What USA	Country?
	ms 23	neral	11 Marital Status 12. Was	Decedent Ever in U.S.	13.			in? (Specify Yes or N Puerto Rican, etc.)	lo-	14. Race - Ar	merican Indian,
9	or Ite	/Fur	1 Never Married 2 Married 1 Yes	d Forces? es 2 ☑ No , Give		fYes, specify Cuba 1 □ Yes 2√⊒ No	n, Mexican, Specify:	Puerto Hican, etc.)		Black, Wi	
21215-0036	hours tural',	d be	3 Widowed 4 □ Divorced Year 15. Decedent's Education	or Dates:		dent's Usual Occupa			1 teh K	ind of Busines	White
15	nin 72 n "nai	plete	(Specify only highest grade comple	ed) ge (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most ()	of working	100. K	ind or busines	is/industry
212	filed with Hygiene other tha	Com	10	ge (1-401 5+)	_	Seams				Cloth	ning
and	be file	Be	17. Father's Name (First, Middle, Last)	t 1 -				's Name (First, Midd		-	
Maryland	should be tand Mental I s marked or umatic eve	2	Henry James M 19a. Informant's Name/Relationship (Type, Print)	onck Friend 19b	. Mailir	ng Address (Street a		<pre>Iyrtle I ror Rural Route Num</pre>	lile: ber. City o		. Zip Code)
	and 2 seath an n 27 is in trau		Rose-Mary Rineheart								, MD 21102
ore,	es 1 a of Hez f item r othe		20a. Method of Disposition 1	20b. Place of		sition (Name of natory or other plac		Date			or Town, State
Ë	nit. Page partment ortant: If injury or		`4 □Donation 5 □Other (Specify)	UIII State	Hil	.1 Cemete	ry 7	7–19–06			Maryland
Baltimore,	permit. Pages 1 and in Department of Health Important: If item 27 any injury or other trong.		21. Signature of Funeral Service Licenses	MO0550				Eline Fu St., Hamp			21074
			23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	nat caused the death. Do non each line.	not ent	er the mode of dyin	g, such as o	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
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0	ires that the signed by I be detact	/ Ph	Part II. Other significant conditions contributing	to death but not resulting in	n the u	nderlying cause give	en in Part I.	23e. Dio	tobacco i	use contribute	to the cause of death?
rds	quires n sign uld be	ed by						1□	Yes 2	□No 3□	Probably 4 X Unknown
Records,	aw require 1s been sig 2 should b	Completed						24a. Wa	s an		autopsy findings available o completion of cause of
R		Com						per	formed? 2 X No	death'	?
Vital	Physician: The lav this certificate has ral director, page 2 a	Be	25. Was case referred to medical examiner? Hospital:			Othe		of Death (Check only			
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Division	or Atte after des Directo	Certification:	3 Suicide 6 Could not be determined 28e. F	lace of Injury - At home, fa uilding, etc. (Specify)	arm, sti	eet, factory, office		28f. Location City or T	(Street an own, State	nd Number or a)	Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) Certifying Physician: T 2 Medical Examiner: On t and	o the best of my knowledge ne basis of examination an manner stated.	e, deat nd/or in	n occurred at the time vestigation, in my of	ne, date and pinion, deat	d place, and due to the h occurred at the time	e cause(s)	and manner d place, and d	as stated. ue to the cause(s)
	To the Comp	Σ	29b. Signature and title of certifier	44.0		29c. License	number 624	534	29d. Da	te signed (Mo	nth, Day, Year)
	11/2/		30. Name and address of person who completed	nause of death (Item 22a)	(Type	Print)	US.	534 T Reis	JUX	7/11/	1300
	4			cause or death (Item 23a)	25	main	Stree	I Reis	Teri	Tow u	MD 2113/
		ate	31. Date filed (Month, Day, Year)	2. Registrar's Signature		,					
	Regist	rar	JUL 1 9 2006	Clown &		porte					

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		1- For State Cert	ificate	of Death		Re	eg. No.	UUb	2431
Physicia	an/	Decedent's Name (First, Middle,Last)				Date of Deat Month		3. Tim	e of Death
ledical Exami	ner	Daniel David Madary				July 17, 20	ooe' ''	20.	25 hrs
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, c	or Location of Deat	h	4c. County	of Death	
		Nazarene Camp		North East			Cecil		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	st birthday				th (MM/DD/YY)	Y) 9. Birthplace	(State or
Director		218-52-4792 1X M 2 F 43		Yrs. Months Da	ys Hours Mir	01/15/	1063	Country D	shingtor C
		Usual Residence of Decedent				101/13/	1903	ν	0
any	- 1	10a. State 10b. County 10c. City, 1	fown or Lo	ocation				10d Ir	nside City Limits
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Maryland 28a-f show d at once.	양	10e. Street and Number	h Eas	10f. Zip Code		10	0g. Citizen of V	Vhat Country?	
or 2	Director	0/ 7		01001				a	
vith th		94 Forge Court 11. Marital Status 12. Was Decedent Ever in U.S	113	21901 Was Decedent of H	ispanic Origin? (S		United	States ce - American Ind	lian Black
ath w	Funeral	1 Never Married 2 X Married Armed Forces?	.	If Yes, specify Cuba				ite, etc.	iran, orack,
er de		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1	Yes 2X N	o specify:		Specify	White	
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36 nin 7; than dical	ed		Толе	ah a se			T-3		
-00- 1 with gience her i	Completed	12 17 17. Father's Name (First, Middle, Last)	lead	cher	18.Mother's Nam	e (First, Middle, N	Educat		
al Hybride	Be C	Charles Boyd Madary				Grace		-,	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To E	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	uling Address (Stre				wn. State. Zip Co	nde)
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and 2 and 2 tem 2 traur		Patricia A. Madary/Wife 20a Method of Disposition 20b. Pl		Forge Cour		Date		- City or Town, S	State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 X Cremation 3 Removal from State	ematory o	r other place)	Ju]	Ly 22,			
Lim Fag ment		4 Donation 5 Other Specify: May	erda]	le Cremato	ory 200			, Delawa	are
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ion tendir eath tor: A	ţi	Natural 5 Pending Fnd 7/17/2006	Fnd 5	5:15 pm 1	Yes 2 No	unk			
	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At hor			building, etc.	28f. Location (S	treet and Num	per or Rural Rout	te Number, City
Divi	Certification:	4 Homicide Adetermined (Specify) found	at ho	me		or Town, Si Northeast	tate) 94 Fo • MD	orge Court	•
Divi		29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge			date and place, and	-		er as started	
Di To the Hospital within 24 hours a To the Funeral I	Medical	one) 2 Medical Examiner; On the basis of examination and							(s)
To with	Me	and manner stated. 29b Signature and title of certifier		29c. Licen	se number		29d. Date sign	ned (Month, Day	, Year)
R.		Dt. A Pall		O.C	.M.E.		July 18, 2		
7/4		30 Name and address of person who completed as use of death them.	330)				, -, -		
/		30. Name and address of person who completed cause of death (ftem 2 Patricia Aronica-Pollak MD. Assistant Medical E	i i	r 111 Penn S	street, Baltimo	re. MD 21201	Ī		
	ate	31 Date filed (Month Day Yoar) 32 Registrar's Signature	as .		,		· · · · · ·		
Regis			sole	/					

State of Maryland / Department of Health and Mental Hygiene / [] [] [For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July Idella 2006 Moreland 11, 7:50 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 16110 Cambridge Court Bowie Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 18,1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☐ XF 82 Washington, DC 220-12-3857 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Heatth and Mental Hygiene. Int: If Itam 27 is marked other than "natural", or Iteme 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or iteme 23s or 28s-f show traumatic event, the Madical Examinat must be notified at 1 Yes 2 XNo Director MD Prince Georges Bowie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 16110 Cambridge Court 20715 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White à Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Citizens Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Norman Franklin Sweeney Idella Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Moreland/ Daughter 16110 Cambridge Court Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Department of important: if any injury or once. Fort Lincoln Cemetery 7/15/2006 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 Approximate Interval Between Inset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) りつつ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien and for use as the burial-transit The law requires that the death certificate be executed Exam Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 ☐ Probably 4 ☐Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 ₩o To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA funeral dir After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c, Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No М investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical 5xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) impleted cause of death (Item 23a) (Type, Print) 30. 1 ne and address of persen Spitel Drive 3. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 1 4 2006

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Maryl	and / Depa		f Health and I	Mental Hy	_	006	2431
	the parties of the pa		Decedent's Name (First, Middle, La	st)				2. Date of Dea		Vane	3. Time of Death
-	Physici		Dorothy Gloria M	oore				Month 7	Day 17 :	Year 2006	4:00 A M
0	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Tow	n, or Location of Death	1	4c. Coun	ty of Death	
50	Exami		Atlantic General	Hospital		Ber1	in		Wor	ceste	r
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday)		ear If Under 24 Hrs.	8. Date of Birt (Month, Da	h v. Year)	9. Birth	olace (State or Foreign
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1	with t	٦	10e. Street and Number	T T					-	Wilat Cou	nu y i
. 1	, 72 hours after death with the Maryland "naturel", or Items 23e or 28e-f show circal Examiner must be notified at	by Funeral	73 Shady Grove I	12. Was Decedent Ever	in II S 12	1997		necify Yes or No.	USA 14 Ba	ce - Ameri	can Indian
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202	yene.	E	12	College (1-401 37)	Se	cretary			U.S.	Coas	t Guard
000	Hyg othe	BeC	17. Father's Name (First, Middle, Last	")			18. Mother's Nar	ne (First, Middle,	Maiden Suma	ime)	
	fenta fenta rked rked	To B	Eugene Bartecchi				Adele	Sylvest	er		
, ; ; s	s 1 and 2 should be filed f Health and Mental Hyg item 27 is marked othe other traumatic event,	ļ-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Str	eet and Number or Ru	ral Route Numbe	r, City or Town	n, State, Zip	Code)
S C	nd 2 s aith an 27 is ir trau	l .	Cindy Chavis (da	ughter)	13 A	nchor W	ay, Berlin	, MD 218	11		
7 5 e	of He of He rothe	1	20a. Method of Disposition	20	b. Place of Dispo cemetery, cre	osition (Name o	f place)	Date	20c. Location	- City or To	own, State
JOE	Pages ento nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci	_Hemovai from State	Cedar Hi			1/2006	Balti:	more,	MD
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Z Z	quires that the de n signed by the a uld be detached f	þ	Part II. Other significant conditions	contributing to death but no	t resulting in the u	underlying cause	given in Part I.				he cause of death? pably 4 X Inknown
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Vital	ician: T	Be	25. Was case referred to medical examiner?	Hospital				ath (Check only o	ne)		_
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	To the Hospital or Att within 24 hours after de To the Funerel Direct completely filled in by t	edical (29a. Certifier 1 🖔 Certifying P (Check only one) 2 🗆 Medical Exa	hysician: To the best of my miner: On the basis of exa and manner stated.	knowledge, dear mination and/or in	th occurred at the	ne time, date and place my opinion, death occu	e, and due to the urred at the time,	cause(s) and n date and place	nanner as s , and due t	stated. the cause(s)
	To th Withir To th comp	ž	29b. Signature and title of certifier	Lace 1		29c. Lic	cense number	Cocker	29d. Date sign	ed (Month,	Day, Year)
			1 9	Porch		Do	005480	7	11	181	Lo
			30. Name and address of person who	completed cause of death	(Item 23a) (Type	, Print)			- 1		
	ET 2		Ramesh K. Aga	rwal. M.D	F.A.C.C.	145 E.	Carroll S	t., Sali	sbury.	Md.	21801
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's S		مو					
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DHMH 17 Rev 1/2001

Registrar

		1	For State	3450	State of Ma	aryland				ealth a	and M	lental F	lygien	LUUL	243	19
6.5			Registrar 1. Decedent's Name (/	First, Middle, La	st)			imour	0 0, 1			2. Date of	Death		3. Time of De	eath
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Viand vild be file Mental Hy	9	To Be	Albert	Winand	У					Dor	othy	y Cha	pman			
	Te .	-	19a. Informant's Name				19b. Maili	ng Addres	s (Street a				mber, City	or Town, State,	Zip Code)	
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Baltimore , Dermit. Pages 1 au Department of Hea	othe	- 1	20a. Method of Dispos			20b. PI	ace of Dispo emetery, crei	sition (Na	me of	a 1	-	Date	20c. L	ocation - City o	r Town, State	
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y sic	9 5	To B	examiner?		Hospital: 1 Inpati	ent 2 🗆 I	ER/Outpatie	nt 3 D	OA Othe	er: 4 Nu	ursing Ho	ome 5 🗆 R	esidence	6 ☐Other (Sp	ecify)	
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DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death. To the Binoral Director: After this certific	completely filled in	Certification;														
hou			29a. Certifier 1 (Check only 2	Certifying P	hysician: To the best miner: On the basis of	of my know	wledge, deat	h occurre	at the tim	ne, date an	nd place,	and due to	the cause(:	s) and manner a	as stated.	
the H iin 24	complete	ledical	onej		and manner st	ated.										
J. A.	2 0	Σ	29b. Signature and tit	e of certifier		>			c. License					ate signed (Moi		
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R	Sta egistr		31. Date filed (Month,	Day, Year)	32 Registr	rar's Signal	ture do	we								

				rtment of Health and Mental Hygiene ifficate of Death Reg. No. 0	6 24320
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last) Mary Ann Nutter 4a. Facility Name (If not institution, give street and number) 205 McKinsey Road	2. Date of Death Month Day Ye. July 4, 2006 4b. City, Town, or Location of Death Severna Park Ac. County of Death Ac.	2:40 a M
F.	Funeral Director		5. Social Security Number 6. Sex 1 M 2 XF 7. Age (In yrs. last birthday) 80 81 Yrs. Usual Residence of Decedent		Birthplace (State or Foreign Country) PA
	the Maryland 28a-f show	ector	10a. State 10b. County 10c. City, Town or Loc MD Anne Arundel 10e. Street and Number	Severna Park 10f. Zip Code 10g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 No
(C)	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23s or 28s-f show other traumatic event, Ita Medical Exercitival mars by notified at	Funeral Director	602 McKinsey Road 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No	as Decedent of Hispanic Origin? (Specify Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - A Black, W	SA whencan Indian, thite, etc.
21215-0036	within 72 hours a ene. than "natural", o	Completed by	15. Decedent's Education 16a. Decede (Give killer. Decedent) 16a. Decede (Give killer.	int's Usual Occupation and of work done during most of working O NOT use retired) 16b. Kind of Busine	ess/Industry
Maryland 21	ould be filed w Mental Hygier tarked other th tatic event, III	To Be Cor	17. Father's Name (First, Middle, Last) Lee E. Isreall	Homemaker Homemaker Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Lena S. Siessmayer	
	ges 1 and 2 short of Health and Ni if item 27 is ma		Robert L. Nutter/Son 521 20a. Method of Disposition 20b. Place 20b. Place	tion (Name of Date 20c. Location - City July 27,	1558 or Town, State
Baltimore,	permit. Page Department of Inportant: if any injury or orce.		21. Signature of Euneral Service Licensee Ba	n National 2006 Arlingto Pranco & Sons, P.A. Severna Park I 5 Gov. Ritchie Hwy, Severna Park,	Funeral Home
8760,	Death certificate be executed Wedical Examiner e attending physician and prior use as the purial-transit	Jical Examiner	23a. Paff. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	in Defficile Colitis Estructure pulmorary de	Interval Between Onset and Death
P.O. Box 68	death certitic e attending p id tor use as	Physician/Med		Ectopic pregnancy 23d. Date of Month	delivery Day Year
	law requires that the de as been signed by the a 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the unc	lerlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3	
tal Rec	2 5 0	e Completed	Certificial Meuropathy 25 Was case referred to medical	24a. Was an autopsy performed? 1 Yes 2 No 1 Y	
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours atter death. To the Funeral Director: Atter this certiticate ha completely tilled in by the funeral director, page	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Manual 5 Pending (Month, Day Year) 29 Accident investigation 3 Suicide 6 Could not be	3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 ☎Other (S 28c. Injury at Work? M 1 □ Yes 2 □ No 28d. Describe how injury occurred	nouse
DİXİ	To the Hospital or Att within 24 hours atter d To the Funeral Direct completely tilled in by		4 Homicide determined 298. Place of Injury - At nome, farm, streed building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	City or Town, State)	as stated
)	To the Ho within 24. To the Fuc	Medical	29b. Signature and title of certifier 30. Name and ddress of person who completed cause of death (Item 23a) (Type, P	29c. License number 29d. Date signed (Mc) 7/13/06	
	Sta Registi		31. Date filed (Month, Day, Year) JUL 17 2006 32. Registrar's Signature	m. bichetberder	46

State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** erman Neuman JUIN 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico H-2CORAGE SPLISBURY
If Under 1 Year If Under 24 Hrs. NURSIX hone 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 1**X** M 2□ F Months 87 219-34-4189 Yrs. 1/29/1919 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits other then "natural", or Items 23s or 28s-f show vent, the Madical Examiner must be notified at 1 ☐ Yes 2√ No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8130 Stevens Road 21804 USA Peges 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer Depertment of Health and Mental Hyg important: If Item 27 is marked other eny injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gustave Neuman Emma Schultz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Lorraine E. Smullen/niece 7826 Greenbriar Swamp Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Smullen Cemetery 7/20/06 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOLLOWAY Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Immediate Cause (Finaf disease or condition resulting in death) Onset and Death CANCER DUD DENAL Physician /Medical Due to (or as a consequence of): Examiner FAILURE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai attending for use as IF FEMALE: 23c. ff yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐-No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 2□ No 1 ☐ Yes 1 ☐ Yes 25. Was case referred o medical examiner? Be 26. Place of Death (Check only one) Hospitaf: Other: 1 ☐ Yes 2 ☑ No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t 5 Pending investigation s after dea. ral Director: After 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D6343 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) SUITE 50 4 B SAUS BURY MO 21804 MILFORS 106 31. Date fifed (Month, Day, Year) 32. Registrar's Signature Registrar 9 2006

			For State Registrar	State of Mar	ryland	-		f Health a of Death	nd Me		giene Reg. No.	2006	24322
			Decedent's Name (First, Middle, La	.st)					1:	2. Date of Dea			3. Time of Death
	Physici		Mary	Jeannette			Petti	6		Month	Day	Yeer	7:25 AM.
\$	/Medic Examin		4a. Facility Name (If not institution, giv					n, or Location of	Death		4c.	County of Deat	1.00
	LXamiii	C!	LIMIK- Brod	dock Cac	nOix		Oum	hoplai	00		(111061	And
	Funeral		5. Social Security Number 6. S	sex 7. Age	(In yrs. last	t birthday)	If Under 1 Ye			B. Date of Birt	h	9. Birt	hplace State or Foreign
	Director		217-28-0467	1□M 2\XF 7	73	Yrs.	Months Da	ys Hours	Min.	(Month, Da) 01/26/	y, re <i>ar)</i> 1933	1 -	untry) `land
7	,		Usual Residence of Decedent								.,,,,,	1 /	
-	No.		10a. State 10b. County	1	10c. City, T	Town or Loca	ation						10d. Inside City Limits
		tol	MD Allega	.ny		Cumb	erland						1∭ Yes 2 □ No
4	or 28	Director	10e. Street and Number				10f. Zip Cod	е			10g. Citiz	en of What Co	untry?
	oeem with the maryland ems 23s or 28s-f ehow		443 Central	Avenue			2	21502				USA	
		Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. W	as Decedent	of Hispanic Orig Cuban, Mexican,	in? (Spec	ify Yes or No-	. 1	4. Race - Ame Black, Whit	
و	rel', or items?		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No	•		☐Yes 2♥					0	
2-003e	illed within 72 hours after Hygiene. other then "naturel", or ite ent, the Medical Examina	d by	3 X Widowed 4 □ Divorced	Year or Dates:				то оросиј.				Specify. V	<i>h</i> ite
ត្ត	natt.	Completed	15. Decedent's E (Specify only highest gra		1	(Give ki	nt's Usual Oc ind of work do	ne during most	of working	g	16b. Kir	nd of Business/	Industry
<u> </u>	9.6	ם	Elementary/Secondary (0-12)	College (1-4or 5+))	life. De	O NOT use re	tired)					
7	be lied within 72 nd tal Hygiene. d other then "natur event, the Madical		12			Se	amstre		1. 11	/F: \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		Manufac	turer
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<u> </u>	snould be ind Mental marked o umatic eve	၉	George	Oliver		ridge		Emma		Ε.		Easto	
_ (, a = 3		19a. Informant's Name/Relationship (-	·	eet and Number					Cip Code)
_	France Health Item 27 other tr		Earl E. Pettie, S	r. / son	20h Blac		b Box	294, Cu	ımber Da			land 2	1501
5			20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □	Removal from State	cem	etery, crema	atory or other	place)				•	
<u>ב</u>	permit. Pag Department Importent: I eny Injury o		4 □ Donation 5 □ Other (Special	*	Davi		orial			2006		berlan	
Baltimore,	Departm Departm Importer eny Inju		21. Signature of Buneral Service Lice	nsee	,			dress of Facility	nuc				l Home, P.A.
ш	10 E E G		Tabet C.	Idone				tur Str				, MD	21502
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line	he death. I	Do not enter	the mode of	dying, such as c	cardiac or	respiratory ar	rest,		Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	CARD	10 EE	ENIC	S	HOCK					Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequer	nce of):							
	Examiner		Sequentially list conditions	. ACUTE			RD1	AL LA	VFA	HRCT	701	U	12 Howes
,	2 =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequer	yce of):							
	and trans	ram	Cause (Disease or injury that initiated events resulting in death) Last	C									
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8760	the the	dical		_ d									
9	attending p	Me	IF FEMALE:	22a Musa sutasma d									
Вох	atin c or us	an	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	☐ Fetal de	eath 3 🗆 E	ctopic pregna				2	3d. Date of dei Month	ivery Day Year
O	the a	Physician/Me	in the past 12 months? 1 □ Yes 2 □ 40 9 □ Unknown	4□Pregnant at tir 9□Unknown	me of deat	h 5∐+	Other (specify	")					,
<u>م</u>	net in		Part II. Other significant conditions	contributing to death but	not resultin	ng in the unc	forhving cause	gwen in Part I		23a Did to	nhacco us	se contribute to	the cause of death?
Division of Vital Records,	Ine law requires thet the death certifications to the steed of the steed of the steed for use as beging to the steed for use as the steed of the ste	þ	, 4	,		u	,,	9.00.1.1.1.4.1.1.			res 2		
5	neen Poulc	etec											
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= '	cete he	ပ္ပ								1 ☐ Yes	med?	death? 1 ☐ Yes	2 □ No
=	Pnysicien: In r this certificete ral director, peg	Be	25. Was case referred to medical examiner?	Line heli					of Death	(Check only o	ne)		
	nysa This c	မ	1 □ Yes 2 □ √0	Hospital:		VOutpatient	3[] DOV			-		Other (Spe	cify)
בַּ	Viter	 0	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) 28	Bb. Time of Injury		njury at Work?		3d. Describe h	now injury	occurred	
Sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	20				1 ☐ Yes 2 ☐ N					
≥ :	efter d Direct d in by	Certification;	4 Homicide determined			e, farm, stree	et, factory, off	Ce	28	City or Tow		Number or Ru	iral Route Number,
<u> </u>	urs e arel D		200 00 480										
:	Fune Fune Fune fely fi	ca	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of e	xamination	edge, death on and/or inve	occurred at the stigation, in n	e time, date and ny opinion, death	l place, ar h occurre	nd due to the d d at the time, d	cause(s). date and	and manner as place, and due	stated. to the cause(s)
	To the Hospital or Arending I within 2 A hours effer death. To the Funerel Director: After completely filled in by the funer	Medicai	one) 29b. Signature and title of certifier	and memoer state	au.		29c Lic	ense number			29d Date	signed (Monta	Day Yearl
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	Sta Registi		JUL 2 6	2006 32. Registrar	Jugiratur	# 1	brack's						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Josephine Marie Policicchio July 15,2006 8:30 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Year) 9. Birthplace (State or Foreign Country) 4 Pennsylvania **Funeral** 1 ☐ M 2 🖸 F Yrs. 91 October 0 **Director** 579-50-9109 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits show in then "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Annapolis 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 528 Coover Road 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2**X** If Yes, Gîve Year or Dates: 2X No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes ZOX No Specify: þ 3[™] Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "n, any injury or other treumetic event, the Media once. Furniture Store $\frac{\text{Elementary/Secondary } (0\text{-}12)}{12}$ College (1-4or 5+) Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mariano Ferruzza Concetta Mary LaRocca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy P. Walsh - Daughter 3301 Rodeo Dr., Davidsonville, MD 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 7/19/2006 Silver Spring, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Pineral Service-bicenses 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): 1 Jeupener **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The taw requires that the death certificate be executed and trans resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 TYes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy certificate 2/2/No 1 ☐ Yes 2 ☐ No Yes Hospitel or Attending Physicien: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Jo 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manne Leath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours atter deave.

To the Funerel Director, Af death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 53306 MD 30. Name and address of person/who completed cause of death (Item 23a) (Type, Print) State RO Manapolis 145 300 WI ORD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 1 8 2006 Registrar

		1 For State Registrar	State of Maryland / De	partment of Health ar <i>ertificate of Death</i>		ene 2006 24324
Physic /Med		1. Decedent's Name (First, Middle, Last)			2. Date of Death	Day 2006 9:00 P M
Exam Funera Directo	iner	5. Social Security Number 6. Sex	hungton Mad. Cont	Months Days Hours	2 Drive Burny	9 Birthplace (State or Foreign
Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Aru	10c. City, Town or undel Crofton	Location		10d. Inside City Limits 1 ☐ Yes 27 No
h with the	al Director	10e. Street and Number 7505 Crofton Color	ny Drive	10f. Zip Code 21114	10g	. Citizen of What Country?
Ind 21215-0036 be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural", or iteme 23a or 28a-f ehow event, the Madical Examiner must be notified at	leted by Funeral	11. Marital Status 1 Never Married 2 M Marned 3 Widowed 4 Divorced 15. Decedent's Edu. (Specify only highest grade	Amed Forces? 1 XYes 2 \(\times \) No 54 - If Yes, Give Year or Dates: 58 cation e completed) 16a. Dec (Gi	3. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F 1 Yes 2 Xo Specify: cedent's Usual Occupation we kind of work done during most or	Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White b. Kind of Business/Industry
d 2121 filed within Hygiene. other than "	e Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	DO NOT use retired) Sineer	Name (First, Middle, Ma	Department of Defense
Maryland d 2 should be file th and Mental Hy ?? ie marked oth traumatic event	To Be	Thomas Phillips 19a. Informant's Name/Relationship (Ty)	no Print)	Anna	Zakrzewski	
C = 14 P		Joan Kelly Phillip	s (Wife) 7505	illing Address (Street and Number of Crofton Colony position (Name of	Dr, Crofton	, MD 21114
Page Bent o nt: if		1 ☐ Burial 2 XX Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Metro Cr	rematory or other place) cematory 07	/18/2006 B	c. Location - City or Town, State
Balti permit Departir Importa any inju		21. Signature of Funeral Service License		22. Name and Address of Facility Hardesty Funera 12 Ridgely Ave.	Annapolis,	MD 21401
bayesicien and burial-transit transit	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Brass STEH J Due to (or as a consequence of):			Interval Between Onset and Death
Geath certiff death certiff e ettending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B ☐ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
COTGS, P.O. **requires thet the dipension of the should be detached.	þ	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
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Phys r this aral di	ertification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 EF/Outpati 28a. Date of Injury (Month, Day Year) 28b. Time Injury	ent 3 DOA Other: 4 Nursin	Death Check only one ong Home 5 ☐ Residence 28d. Describe how i	
DIVISION tal or Attending is after death. al Director; Afte	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Al home, farm, s building, etc. (Specify)	street, lactory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
the Hospi kin 24 hou the Funer ipletely fill	edicai	one)	ician: To the best of my knowledge, der er: On the basis of examination and/or and manner stated.	ath occurred at the time, date and p investigation, in my opinion, death o	lace, and due to the causi occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To with To t	Σ	The state of	Wich I M.D		J.	Date signed (Month, Day, Year) Ny 15 , 2006
		30. Name and address of person who con		Hospital Drive	e, Glen Bu	rnie, MD. 21061
St Regist	ate rar	31. Date filed (Mortin Pay, 1et 200	Registrar's Signature	well .		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Rocco Michael Paone 1:30 P M July 16 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heritage Harbour Health & Rehab. Anne Arundel Annapolis 8. Date of Birth (Month, Day, Jan 19, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Sex 2 F 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 065-03-5246 92 New York Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow r than "natural", or items 23a or 28a-f eho the Modical Examiner must be notified at Anne Arundel Maryland Annapolis 1 Yes 20No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1001 Boom Court 21401 U.S.A. Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. MXYes 2 □ No If Yes, Give 1941-73 Year or Dates 1 Never Married Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes XX No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) College Professor Education permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygie.
Important: If item 27 is marked other ti
any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick Paone Grace Cerasulo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Paone/son 47 Williams Drive Annapolis, Maryland 21401 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. Mary's Cemetery 7/19/2006 Annapolis, Maryland 21. Signature of Puneral Fervice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine led by the attending physicien and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown should I 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? hes certificate 1□ Yes 1 ☐ Yes 2 ☐ No 2 12 No r: After this certifica e funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: 1 Tes Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending Injury death. 1 Tes 2 No investigation nours after death nerel Director: / / filled in by the f 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a
To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

State Registrar 29b. Signature and

arti

31. Date filed (Month, Day, Year) JUL 18 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

of certifies



Box 68760

Division of Vital Records, P.O.

29d. Date signed (Month, Day, Year)

		1 - For State Registrar	State of Maryland		artment o				giene Reg. No. 2	106	2432
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/Medic Examir		4a. Facility Name (If not institution, give 92 Connelly Road			4b. City, Tov Risi	vn, or Location		July	4c. Count	006 y of Death Cil	
Funeral Director		5. Social Security Number 6. Se 215-42-7065 Usual Residence of Decedent	x 7. Age (In yrs. last 63		If Under 1 Y Months D	ear If Undays Hou	der 24 Hrs. rs Min.	8. Date of Birt (Month, Day July 2	v. Year)	9. Birth Cou	place (State or Foreign Intry) WV
within 72 hours after death with the Maryland ene. than "natural", or Iteme 23a or 28a-f ehow the Medical Exeminer must be notified at	Director	10a. State 10b. County MD Cecil	10c. City, T.	own or Lo	Sun						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
ath with the 23a or 2	rai Dire	10e. Street and Number 92 Connelly Road			10f. Zip Co	11			10g. Citizen of USA		
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1 and 2 should Health and Men I marke		19a. Informant's Name/Relationship (7) Patricia Price/wif 20a. Method of Disposition	ie	92 C		, Road	, Risi	ing Sun	r, City or Town	1911	
Page nent o ant: If ary or		Wathout of Disposition WXBuriai 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	Removal from State West	etery, cren Nott	natory or other ingham	r piace) Cemet	07-22 ery	2-2006	Colora	, Mar	
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Physician /Medical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	(10.1.0	~ <i>C 2</i> ce of):	v						Interval Between Onset and Death 2 yelly 5
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cate be executed physicien and the burial-transit	dlcal	resulting in death) Last	Due to (or as a consequent	ce of):							
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w requires that been signed b should be deta	۾	Part II. Other significant conditions co	ntributing to death but not resultin	g in the ur	nderlying caus	e given in Pa	urt I.		obacco use con	tribute to t	the cause of death?
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Physician: The law requires t this certificate hes been signe ral director, page 2 should be o	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔊 No	fospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatien	t 3 DOA	Other		ne 5 K Resid		ner <i>(Speci</i>	fy)
ding Afte fune	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	Injury at Work? 1 Yes 2	□No		low injury occur		al Route Number.			
- 10 F		4 Homicide determined 29a. Certifier 1 Certifying Phy	28e. Place of Injury - At home building, etc. (Specify)	dge, death	occurred at the	ne time, date	and place a	City or Tow	m, State)	anner as s	stated
To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical Examione) 29b. Signature and title of certifier	iner: On the basis of examination and manner stated.	and/or inv	estigation, in i	cense numb	death occurre	ed at the time, o	date and place, 29d. Date signe	and due t	O the cause(s) Day, Year)
2+ IVA		30. Name and address of person who or		. /		57	14		Tuly 1	7, 2	2006
Sta Registr		31. Date filed (Month, Day, Year)	32. Redistrar's Signature	HUSI	houts	Elk	lon,	mp			

06-05102 Luis Vargas

Please Type or Print in Black Indelible Ink

Luis Vargas State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day July 16, 2006 **Medical Examiner** Luis Alberto Vargas Ramirez 1315 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Crownsville, MD Rear or 314 Kyle Road Anne Arundel 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Foreign Country)Mexico Hours Director 1 X M 2 F none 16 05/13/1990 Yrs Usual Residence of Decedent 10a State 10c. City, Town or Location 10d Inside City Limits 28a-f shov 1 X Yes 2 No Maryland notified at once. Anne Arundel Annapolis with the Maryland Director 10e. Street and Number 10g. Citizen of What Country 10f. Zip Code 8 Johnson Place 21401 Mexico or items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 4 Race - American Indian, Black hours after death 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2X No Yes f Yes. Give Year Widowed Divorced 1 X Yes 2 No specify: Mexican White Specify than "natural". <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed , MD 21215-0036 and 2 should be filed within 72 he ealth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Landscaper Landscaping Pages I and 2 should be filed with nent of Health and Mental Hygiene ant; If item 27 is marked other 1 17. Father's Name (First, Middle, Last) 1B.Mother's Name (First, Middle, Maiden Surname) Esteban Vargas Merino or other traumatic event, Concepcion Ramirez Hernandez 19a. Informant's Name/Relationship (Type, Print) Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip Code) Esteban Vargas Merino/father 21401 <u>Annapolis, Maryland</u> 20a Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State permit Pages
Department of
Important: I 07-24-2006 | Mexico Donation 5 Other Specify Family Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc. 3447 14th Street, N.W. Washington, D.C. 20010 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a Drowning Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. ne if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Essable or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical UNPENDED ending physician use as the burial -**AMENDED** item#1,perME,g858,8/11/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE 23d Date of delivery 23c. If yes, outcome of pregnancy 3b Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month 2 Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Q Unknown signed by the the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 V No 3 Probably 4 Unknown Completed s been s 24a. Was an 24b Were autopsy findings available prior to completion of cause of death? autopsy this certificate has performed Yes 2 1 🗸 Yes 2 No To the Hospital or Attending Physician; within 24 hours after death 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene ပ 1 V Yes 28a. Date of Injury Jul 15, 2006 After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Subject drowned 1 Natural 1830 hrs Pending 1 Yes 2 V No within 24 hours after death To the Funeral Director: the 2 🗸 Accident Investigation 2Be. Place of Injury - At home, farm, street, factory, office building, etc. 2Bf. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be (Specify) River Rear or 314 Kyle Road, Crownsville, MD Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and mannel stated. 29b. Signature 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E July 17, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Susan Hogan MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Registrar's Signature. Registrar 8

		1	For State Registrar	Si	tate of Ma	aryland / i	Department Certificate				ene 2006	24328
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н	Physicia /Medic		Roy J. Ramho	off							v 23. 2006	09:15 AM
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e .	Funeral		5. Social Security Number	6. Sex 1 ∑ M	2 🗆 F	e (In yrs. last bi	rthday) If Under 1 Months	Days Hours	Min.	ate of Birth Month, Day, Y	(ear) C	nthplace (State or Foreign ountry)
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	/land		10a. State 10b. 0			10c. City, Tow	n or Location					10d. Inside City Limits
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician July 17, 9:00 A 2006 Donald Preston Rau, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Village Montgomery 9713 Lake Shore Drive If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 60 1⊠M 2□F 217-44-8565 Dec. 5, 1945 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County in then "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 XYes 2 No Montgomery Village Montgomery Maryland Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20886 9713 Lake Shore Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1XYes 2□No If Yes, Give Vietnam Year or Dates: within 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify: Maryland 21215-0036 Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Foreign Language Typesetter Typesetting 12 d 2 should be filed with and Mental Hygie 7 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beverly K. Sadtler Donald Preston Rau ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 le any injury or other trau once. 101 Odendhal Avenue, #1006, Gaithersburg, MD 20877 Beverly K. Rau/ Mother Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Metropolitan July 18, 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Crematory DeVol Funeral Home, 22. Name and Address of Facility 21. Signature of Funeral Service License, 10 East Deer Park Drive, Gaithersburg, MD 20877 Ranti Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction **Physician** /Medical Due to (or as a consequence of): Examiner Atherosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š Division of Vital Records. 8 Chronic Renal Failure 1 Tes 2 No 3 Probably 4 Unknown Completed s peen s 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 X No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 X Yes 2 No 4 Nursing Home 5 ■ Residence 6 Other (Specify) 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: After 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only ihe i 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 D35103 July 17, 2006 10+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Vaccarezza, M.D., 6240 Montrose Road, Rockville, Maryland 20850

Registrar

31. Date filed (Month, Day, Year)

JUL 19 2006

32. Registrar's Signature

				rtment of Health and Menta	Il Hygiene	24330
	N 4	¥	Decedent's Name (First, Middle, Last)	2. Dat	e of Death	3. Time of Death
- 3 ⁴	Physici		110363 DILLETI	J. Wo	3 11 -	9535 M
	/Medic Examin		and the second s	4b. City, Town, or Location of Death	4c. County of Dea	- 0 - 0
	Examili	er	Prince George's Hospital	Chaverly	Prince	Genzos
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date	e of Birth 9. Bir	thplace (State or Foreign
	Director		223–56–4866 ¹ X ^M ² □ F 62 Yrs.	Months Days Hours Min. Jul	y 16, 1944 Vir	ginia
	P		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	***		10d. Inside City Limits
	show	_				tyE Yes 2 □ No
	88-1	Director	DC Washingto		10g. Citizen of What Co	
	s within 72 hours after death with the Maryland liene. r than "naturel", or iteme 23a or 28e-1 show the Medical Examinar must be multified at			10f. Zip Code 20019	United Sta	•
	sath ve 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. y	Vas Decedent of Hispanic Origin? (Specify Ye		
	Herr d	'n	Agned Forces? 1 Never Married Amarried 1 Never Married Amarried 1 Never Married Amarried 1 Yes, Give	Yes, specify Cuban, Mexican, Puerto Rican,		
21215-0036	irs at	by	tf Yes, Give 8/28/61 3 □ Widowed 4 □ Divorced Year or Dates: 1/10/64	Yes 2 No Specify:	Specify:	lack
ğ	72 hou	ted	15. Decedent's Education 16a. Decedentia	ent's Usual Occupation kind of work done during most of working	16b. Kind of Business	
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21	d wit	Completed	Elec	trician	Federal	
pu	be filed tal Hygi of other event, I	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	Middle, Maiden Sumame)	
/la	should be ind Mental marked o	일	Glenn Wright	Emmaline	Smith	
Maryland	d 2 should bette and Ment is marked traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	g Address (Street and Number or Rural Route		
	is 1 and 2 of Health a item 27 is other trait			Benning Road SE #304		
ore			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	sition (Name of Date natory or other place)	20c. Location - City or	r Iown, State
Ë	Pages ment of l		4 □Donation 5 □Other (Specify) Quantico	National Cem. 7/24/2 Name and Address of Facility	2006 Triangle,	Virginia
Baltimore,	permit. Page Department Important: if eny injury o		21. Signature of Funeral Service Licensee	A. cestville, Mary	land 20747	
	· · · · · · · · ·		23a. Part Enter the disease, or complications that caused the death. Do not ent shock or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or respir	ratory arrest,	Approximate Interval Between
	Physician			Cardiovisentes He		Oncot and Doath
1	/Medical		resulting in death) Due to (or as a consequence of):	344	03.0	
1	Examiner		Sequentially list conditions b.			
		ner				
	ransi	Examlner	cause. Enter Underlying Cause (Disease or injury that initiated events c			
Ó,	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	E	resulting in death) Last Due to (or as a consequence of):			
8760,	cate by	dical	d			
9	ing p	Mec	IF FEMALE:			
Box	eath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy	23d. Date of de Month	elivery Day Year
o.	at the dei by the a tached f	/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		
Θ.	that the			nderlying cause given in Part I. 23	se. Did tobacco use contribute t	to the cause of death?
ds,	signe	1 by			1 Yes 2 No 3 P	robably 4 Unknown
of Vital Records,	w require been si should I	Completed				
3ec	e law has b	ldr			la. Was an autopsy performed? 24b. Were a prior to death?	utopsy findings available completion of cause of
H F					Yes 2d No 1 ☐ Ye	s 2□ No
V:E	Physicien: Th this certificete ral director, pag	Be		26. Place of Death (Chec		
ot	phys this aldi	2	1 Inpatient 22 Envoutpatier	4 DIAGISING TIONS 3	Residence 6 Other (Speed escribe how injury occurred	ecify)
		lo lo	1. Natural 5 Pending (Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		
Si	or Attending after death. Director: After in by the fune	lca	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str		cation (Street and Number or F	Rural Route Number,
Division	P of the	Certification:	3 Suicide 6 Could not be determined 289. Place of Injury - At home, farm, stream of the building, etc. (Specify)	Cit	ty or Town, State)	
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	<u>a</u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat			
	• Ho 124 Fu • Fu letely	ledlcai	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the	he time, date and place, and du	e to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	nth, Day, Year)
	(D) 111		Solvada Advito Do	180053927	July 17	2006
)	(Q) \Va		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	1	
	U 111		Sulvendor Sylvester 3001 Hospit	af Drive, Chuery	y man / as	ol
16	St	ate	31. Date filed (Month, Day, Year) 2. Registrar's Signature JUL 1 9 2006	1.0		
*	Regist	rar	JUL 1 9 2006 Klein & gra			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 10, July 2006 11:52 a^M Samuel Shin /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□F 2006 July 10, Maryland Director None Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in then "naturel", or Items 23a or 28e-1 show the Medical Evandruct must be notified at 1 ☐ Yes 2 X No Director Burtonsville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13504 Greencastle Ridge #202 20866 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: Specify: Asian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within the and Mental Hygiene.
7 Is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) None other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Shin Yoon Jung In Shin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is rr any injury or other traum once. 13504 Greencastle Ridge #202; Burtonsville, MD 20866 Yoon Shin / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 7/18/2006 Brentwood, Maryland 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 21. Signature of Funeral Service Licensee 1040 Rockville Pike; Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Trisomy 13 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Year 5 Other (specify) ate has been signed by the a page 2 should be detached to Division of Vital Records, P.O. 9 Dlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 X No 1 Tyes filled in by the funeral director, 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funerel Direct completely filled in by 4 - Homicide ō 29a. Certifier 🛮 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 22868 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15215 Shady Grove Road; Rockville, Maryland 20850 Jill J. Ladd, M.D. 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature State JUL 19 2006 Registrar

			1 - State of Maryland / Depa	rtment of Health and I		ene 2006	24332
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Gloria Oliva Savage		2. Date of Death Month July		3. Time of Death 2:10 P M
de la companya della companya della companya de la companya della	Examir		4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Havre de Grace If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death Harford	place (State or Foreign
	Director		213-24-0529	Months Days Hours Min.	(Month, Day, Feb. 14	, 1928 Mary	land
	be filed within 72 hours after deeth with the Maryland ital Hygiene. Id other than "naturel", or items 23a or 28a-1 ehow event, the Medical Exeminar miss the notified at	rai Director	Maryland Cecil North East 10e. Street and Number 1433 West Old Philadelphia Road		1	ng. Citizen of What Cou United Stat	
-0036	2 hours after de aturel', or items cal Examinar n	ted by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give 1 ☐ Yes, Give Year or Dates: 15. Decedent's Education 16a. Decede	las Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puert ☐ Yes 2 ☑ No Specify: ent's Usual Occupation	o Rican, etc.)	14. Race - Americ Black, White, Specify: Whi 6b. Kind of Business/in	etc. Lte
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Balt	permit. Departm Importa any nju	TA:	21. Signature of uporal Savice Licensee 22.	Name and Address of Facility Co	ouch Fun	eral Home East,Maryl	and 21901
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	cate be executed bhysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. ACUTE MYBCA Due to (or as a consequence of): C. Due to (or as a consequence of): d.	ARDIAL INFA	L CTI ON		8 days
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Records, P	The law requires that ite hes been signed b page 2 should be deta	2	Part II. Other significant conditions contributing to death but not resulting in the uncommendations MULTIPLE STROKES DIABETER MFLLITUS	lerlying cause given in Part I.		cco use contribute to the	ne cause of death?
		e Completed	DIABETER MELLITUS HYPERTENSION 25. Was case referred to medical			prior to cor death? ■No 1 □ Yes	psy findings available inpletion of cause of 2 No
5	ling Phys 1. After this Tuneral dii	ToB	examiner? 1	0.0	th (Check only one) ome 5 Residen 28d. Describe how	ce 6 □Other (Specify	()
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	To the Hospital of within 24 hours af To the Funeral Discompletely filled in	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or inversion and manner stated.	stigation, in my opinion, death occur 29c. License number	red at the time, dat	se(s) and manner as st e and place, and due to I. Date signed (Month, I	the cause(s)
•	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	D-15994		7-17-06	
	Sta Registr	te ar	LETICIA S, GALVEZ, MD, 625 S.U. 31. Date filed (Month, Day, Year) JUL 1 9 2006 32. Fegistrar's Signature	WION AVE, HAV	re de c	TRACE N	D 21078

James Harold Sewell 06-04878

UNK UNK

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 24333

		1- For State Registrar		Cei	rtificate o	f Death	7				Reg No	1.00		
Physicia	_	Decedent's Name (First, Midd	lle,Last)						2	Date of De		Voor		3. Time of Death
dical Exami		James Ha	rold Sew	æll						Month July 9, 2	006 006	Year		1808 hrs
		4a Facility Name (if not institution				4b. City, To	own, or Lo	ocation of	f Death			County of	f Death	
		Route 5 south of Earr		,		Clintor					Р	rince G	eorge'	s
		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast hirthday)	If Unde	r 1 Year	If Under	24Hrs	8. Date of F	Birth (MM/E)D/YYYY)	9. Birth	place (State or
Funeral		5. Social Security Number			ast biltinday)	Months	_	Hours	Min.	Decei	mber	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Foreign	Maryland
Director		213-76-7702	X M 2 F	45	Yrs	i.				3,19	60		Cou	ntry)
	- 1	Usual Residence of Decedent												
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daryland 28a-f show datonce.	용	10e. Street and Number				10f. Zip	Code			T	10g. Citiz	en of Wh	at Count	ry?
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5-0036 iled within 77 Hygiene Jother than	0	17. Father's Name (First, Middle							·			·		
21 be f ental rrkec	å	James Lee Ta	ft			· 	l_	Mary	у Са	ther	ine	Sev	vel]	
2. noulcount of M. is my	2	19a Informant's Name/Relation			8 ⁹ 7 20	Robe	(Street	More	berorRu Gan	Pl -	umber, Cit	y or Town	, State,	Zip Code)
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Heal Heal		20a Method of Disposition 1 X Burial 2 Crematio	n 3 Demousle		Place of Dispo- crematory or of			etery,		Date	20c. L	ocation -	City or T	own, State
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Mental Hygiene unt: If item 27 is marked other than "natural", or items 23a or 28a-f she in other traumatic event, the Medical Examiner must be notified at once					.Marys			h	7-20	0-06	Bry	anto	own	Maryland
Itin it P ortan		4 Donation 5 Other S 21. Signature of Funeral Service						1			_			_
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 'Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other tranmatic event, the Medic		21. Signature of Funeral Service Ocensee 22. Name and Address of Facility Adams Funeral Home F 191 20605 Aquasco Rd, Aquasco MD 2060											508	
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Physician /Medical		failure. List only one cause	e on each-line.				, .			, ,				Between Onset and Death
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Division of Vital Records, tal or Attending Physician: The law requires a star death. In Director: After this certificate has been sided in by the funeral director, page 2 should be	B B	examiner?	Hospital:	Inpatient 2	ER/Outpatien			\45====		Home 5	Posidor	nce 6 🗸	Othor	Scano
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Divisior To the Hospital or Attend within 24 hours after death To the Finneral Director: completely filled in by the	Medical	one) 2 Medical Ex	aminer: On the basi and manner		and/or investiga	ation, in my	opinion,	death occ	curred at	the time, dai	te and pla	ce, and du	e to the	cause(s)
F W F O	₽	29b. Signature and title of certif				290	License	number			29d E	ate signe	d (Mont	th, Day, Year)
		Delos 2	-				O.C.N	1.E.			July	10, 200	06	
		30. Name and address of person	on who completed ca	use of death (Iter	m 23a)									
XR 7			ssistant Medica			Street, B	Baltimor	re, MD :	21201					A)
NOW.				Refustrar's Signa	ture 1 -	1 15								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month **Physician** LICE Ith 2006 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Severna Park Sunrise Assisted Living Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F 022-07-8158 95 Director MA Apr. 7, 1911 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at Anne Arundel Be Completed by Funeral Director Severna Park 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 West McKinsey Road 21146 USA Itema 23e 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 ō White If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify 3X Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Insurance Company Data Processor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ! Patrick Carroll Mary Ellen Kenny ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Nancy E. Duffy/Daughter 322 North Putney, Severna Park, MD 21146 Baltimore, July 15, 2006 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 0 = 6 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If ony injury or once. Annapolis, MD Hillcrest Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service bicen 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 23a. Part. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

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A Approximate Interval Between Onset and Death Immediate Cau (Final di yease or condition risulting in death) Physician LUNG CANCER 3 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HRONIC GBSTRUCTIVE PULMOWARY 2 🗆 No 3 Probably 4 Unknown HYPORTONSI 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of sause of death? 2 1No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 ther (Specify) ASSISTED 1 Yes 2 No 2 ER/Outpatient 3 DOA by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident within 24 hours after deat To the Funeral Director: completely filled in by the 3 🗀 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) Michael Ankrom MD 860 Vote Work LICHWAY SITELLA MILLERSVILLE WIDE 31. Date filed (Month, Day, Year) 7 2006 Registrar

		1	For State Registrar	8	State of Ma	arylan		artment of H		and M		jiene _{log. No.} 2 (006	24335
	Physicia		Decedent's Name (First, Midd.			_					2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic	al	Lloyd 4a. Facility Name (If not institutio		thaniel		wigg	4b. City, Town, or	Location		JULY	26 200	06 y of Death	10:40 A ^M
	Examin	er	MEMORIAL HO					CUMBERI		,, 554			EGANY	
	Funeral Director		5. Social Security Number 214-07-4988	6. Sex	7. Age	e (In yrs. 98	last birthday) Yrs.	If Under 1 Year Months Days	If Under : Hours	24 Hrs. Min.	8. Date of Birth Month, Day Apr 19,	1908	9. Birthi Cou	place (State or Foreign
	and	h	Usual Residence of Decedent 10a. State 10b. County			10c. Cit	y, Town or Lo	cation					Ţ.	10d. Inside City Limits
	Mary	to	MD Alle	gany			Cuml	perland						1 ∑Yes 2 ☐ No
	or 28	Funeral Director	10e. Street and Number	_				10f. Zip Code	04500		1	10g. Citizen of		ntry?
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36	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f show than Modical Exercities must be notified at	þ	1 Never Married 2 Mar 3 Widowed 4 Divorced	ried	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2 💆 No	n, Mexican	, Puerto	Rican, etc.)	Speci	ack, White,	etc.
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Maryland	hould be d Mental marked c matic eve	To Be	William U. To	00	Print)		19b. Maili	ng Address (Street a			(Eyler)		n. State, Ziu	o Code)
	nd 2 salth an 27 is or trau		Naomi Twigg		wife			Oldtown F				erland	M	21502
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, it a Medical Examinat must be notified at once.		20a. Method of Disposition 1 ↑ Output 1 Output I Output		noval from State	0	emetery, crei	esition (Name of matory or other place lemorial Gar			7/29/2006	20c. Location		own, State
Balti	permit. Depertrainmports any inju		21. Signature of Funeral Service	Licensee	110	U	1 22	2. Name and Address Scarpell 108 Viro			ome, PA e: Cumber	land. ME	21502	2
	Physician		23a. Part 1. Enter the disease, of shock or heart failure. Lis	t only one	cause on each li	ne.		er the mode of dying	g, such as	cardiac o	or respiratory are	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		diséase or condition resulting in death)		MYOCARD Due to (or as			TION						4 DAYS
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P.O.	that the ed by detac	/Ph	Part II. Other significant condit	ions contr	ibuting to death b	ut not res	ulting in the u	nderlying cause give	en in Part I		23e. Did to	bacco use co	ntribute to t	the cause of death?
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ono	ding After fune	tlon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pend 2 ☐ Accident inves	ng igation	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	Worl	yat k? Yes 2 🗍		28d. Describe h	low injury occi	irred	
Divisi	i or Attendesti efter desti i Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could	not be mined	28e. Place of Inj building, et	ury - At h c. <i>(Speci</i>	ome, farm, st fy)	reet, factory, office			28f. Location (S City or Tow		nber or Rur	al Route Number,
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•	6		30. Name and address of perso DR.VIK POONAI		spleted cause of c			Print) RLAND, MAR	RYLANI) 2	21502			÷
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The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

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rat', or Itama 23a or 28a-f ahow Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Itan Important: or ther traumatic event, the Modical Examina any hiptry or other traumatic event, the Modical Examina any

Baltimore, Maryland 21215-0036

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IF FEMALE 23b. Was decedent pregnant in the past 12 months? t □ Yas 2 □ No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 9 Unknown

3 ☐Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

2 🖾 No

2√ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

1 XNatural 5 Pendina 2 Accident 3 ☐ Suicide

4 Homicide

(Check only one)

29a. Certifier

investigation 6 Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier a. Farsm mp yeh acy

D02237

29c. License number

29d. Date signed (Month, Day, Year) JULY 18, 2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARDSON FARSON M.D. # 10 ST PATRICK DRIVE # 203 WALDORF, MARYLAND 20603

State Registrar

2

31. Date filed (Month, Day, Year) JUL 1 9 2006

32. Registrar's Signature Blave & Spark

			1 - State Registrar	State of M	aryland / Depa	artment of H		F	eg. No UU	6 24337		
2	Physici		1. Decedent's Name (First, Middle, Last) Joyce Frost Tilgh	man				2. Date of Dea Month July	Day Ye	3. Time of Death 906 4:30 P M		
	/Medio Examin		4a. Facility Name (If not institution, give st Anne Arundel Medic			4b. City, Town, or	nnapolis	th	4c. County of [
*	Funeral Director		220 30 3031	7. A	ge (In yrs. last birthday) 80 Yrs.	ff Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)	Birthplace (State or Foreign Country) South Carolina		
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State Maryland Anne Aru 10b. County Anne Aru	ndel	10c. City, Town or Lo		Arnold			10d. fnside City Limits 1 ☐ Yes ※XNo		
	h with the	Funeral Director	10e. Street and Number 306 Rugby Cove Roa	d		10f. Zip Code	21012		0g. Citizen of Wha			
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental rlygiene. Item 27 is marked other then "naturel", or iteme 23s or 28s-f show other traumatic event, the Madical Examiner rivel be notified at	by	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces' 1 Yes 200 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ※ No	ispanic Origin? (: an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc. White		
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	and 2 shoul salth and M n 27 is marl		19a. Informant's Name/Relationship (Typ Thomas O. Tilghman					arnold, Ma	r, City or Town, Sta aryland	21012		
Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 5 any injury or other once.		20a. Method of Disposition 1 💆 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		St. Anne	s Cemete	ry 7/1	9/2006		s, Maryland		
Ball	permit Depart Import any in		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complice	Justo	7 14	17 Duke o	f Glouce	ester St.	, Annapol	eral Home is, MD 21401		
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on of Vital	Attending Physician: "r death. r death. ector: Atter this certifica by the funeral director. p	tlon: To Be	examiner? 1 Yes 2 No									
Division	ef or Attendi s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	ifury - At home, farm, str tc. (Specify)	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,		
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)	To the within 2 To the complet	M	29b. Signature and title of certifier	-	. A	29c. Licens		1	29d. Date signed (A			
			30. Name and address of person who con	npleted cause of	death (Item 23a) (Type,	Print)	d As	mapolis	7/15/0	2/40/		
JE .	Sta Regist		31. Date filed (Month, Day, Year)		trar's Signature	out !	O'					

n1	s, Alle		23a(a), 23a(b); ny County, Ple	ease Type			ndelible lnk		•	9	e.	
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	Physici	20	1. Decedent's Name (First, Mic	idle, Last)					2. Date of Dea		3. Time of Dear	th P
	/Medi		Norman Ralph		9.5				July	26,200	6 1850	M
· de	Examir	er	4a. Facility Name (If not institut		1		10 1	or Location of Death		4c. County of t	Death Co. In . I	
			5. Social Security Number	6. Sex		mpus (In yrs. last birthda	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h 9	Birthplace (State or For	reian
L	Funeral Director		559-28-8609	150 M 20		88 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day 14-Jun	-1918 (Ohio	oigii
	and and		Usuel Residence of Decedent 10a. State 10b. Cour	nty		10c. City, Town or	Location				10d. Inside City Lin	nits
	r 28a-f show	tor	Maryland A	Allegany		Frostburg					1 Yes 2□]No
	€ 0 M	Director	10e. Street and Number 17	Greenbrier	Court		10f. Zip Code			10g. Citizen of Wha	t Country?	
	ler death w	Funerai	11. Marital Status	12 Was	Decedent E	verinits 13	21532-		nacity Vac or No.	U.S.A.	American Indian.	
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Maryland 21215-0036	ld be filed with ental Hygiene. ked other ther ic avant, Iba N	To Be C	17. Father's Name (First, Middle Ralph Ulrey	le, Last)				18. Mother's Nam		Maiden Sumame)		
Mary	s 1 and 2 should be if Health and Mental item 27 is marked oother traumatic ava		19a. Informant's Name/Relatio Barbara Schafe		Half-si		ling Address (Street White Ave.	and Number or Ru		r, City or Town, Sta Marylar		1
ē,	of Heali of Heali itam 2 other		20a. Method of Disposition			20b. Place of Dis	oosition (Name of		Date	20c. Location - City		-
Ë	Page ent c nt: if		1 ☐ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		from State		ematory`or other pla nd Crematory	2	7-Jul-2006	Cumberland	Maryland	
Baltimore,	permit. Departminporta		21. Signature of Funeral Service	ce Licensee	rit		22. Name and Addre Durst Fune		Frost Ave.	, Frostburg, N	MD 21532	
	Physician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. L' Immediate Cause (Final disease or condition resulting in death)	ist only one cause	on each line	the death. Do not e		ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death Twelve Hrs	1
68760,	icate be executed physician and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C		consequence of):						
P.O. Box 687	ath certif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	10	s, outcome o Live birth 2 Pregnant at t Unknown	Fetal death 3	□Ectopic pregnancy	/		23d. Date of Month	delivery Day Year	
	ires that the de signed by the a i be detached f	by P	Part II. Other significant condi	itions contributing	g to death bu	t not resulting in the	underlying cause giv	en in Part I.		_	e to the cause of death?	
Records,	> 0 0	eted		erchia	0 In	IRROT	U		-			
i Re	The la ete hes page 2	Completed by	CHRONI	C 0851	RUCT	IVE Pul	morrary ?	DISEASE	24a. Was a autop: perfor	sy prior med?/ deat	autopsy findings availa to completion of cause h? Yes 2 \(\subseteq \text{No} \)	of
Vital	Physician: The this certificate al director, pag	Be (25. Was case referred to media					26. Place of Deal	h (Check only or	ne)		
) [shys this al dir	၉	1 ☐ Yes 2 No	Hospital:	1 Inpatier			4 Littorshing Fit		ence 6 □Other (S	Specify)	
n o	a <u>a</u> a	ő	27. Manner of Death 1 ☑Natural 5 ☐ Pend		Date of Injury (Month, Day	Year) 28b. Time Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	ow intury occurred		
Division of	Attending r death. Actor: After	licat	3 ☐ Suicide 6 ☐ Coul		Place of Iniu	ry - At home, farm, s		165 2 140	28f Location (S	treet and Number o	r Rural Route Number.	
Ö	after after Dire	Certification:	4 Homicide	mined 289.	building, etc.	(Specify)	aroot, lactory, office		City or Tow	n, State)	Tibrar Toble Number,	
	~To the Hospital or Attendin within 24 hours after death. • To the Funeral Director: Att completely filled in by the fun	Medical C	29a. Certifier 1 Certify (Check only one) 2 Medic	ai Examiner: On	To the best of the basis of I manner stat	examination and/or i	ath occurred at the tire	ne, date and place, pinion, death occur	and due to the c	ause(s) and manne late and place, and	r as stated. due to the cause(s)	
	o tha	Me	29b. Signature and title of certification		aimoi sidi		29c. Licens	e number	2	9d. Date signed (M	onth, Day, Year)	
	1 /		> 5(hou	yn	n. 0	7:	2563	8 5	Janle.	27 2001	6
	DRI TOR		30. Name and address of person	on who completed			p, Print)	Frost be	ng Ma	Mala 1	21537	/
	Sta Registr		31. Date filed (Month, Day, Yea JUL 2	ar)	32. Registra	-	Speeks	4'		- News	21322	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Month Year Sandra Helena July 14,2006 1:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20 Collinson Lee Lane Edgewater Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🗓 F 64 March 11,1942 Maryland 215-40-6053 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Iteme 23s or 28e-f show the Medical Examiner must be notified at Edgewater 1 Tyes 2XXNo Maryland Anne Arundel Directo 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 21037 USA 20 Collison Lee Lane death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status of filed within 72 hours after it Hygiene.

other than "natural", or Ite 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry \$tate of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Secretary 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked oth any injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Owsik Laura Dulski Stanley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20 Collison Lee Ln., Edgewater, MD 21037 Nelson L. Vann - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tXXBurial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Memorial Gds. 7/18/2006 Davidsonville, MD 4 ☐ Donatiops 5 ☐ Other (Specify) Funeral Service Vicensee 21. Signaturi George P. Kalas Funeral Home, P.A. 2973 Solomons Island Rd., Edgewater, MD 21037 0 23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OF Physician CANCER YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner death certificate be executed burial-transit Due to (or as a consequence of) physician s the burial Box 68760. Physician/Medical the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 20 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Division of Vital Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 28b. Time of Injury To the Hospitel or Attending Pt within 24 hours after death.
To the Funerel Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29b. Signature and file of certifier 29c. License number 29d. Date signed (Month, Day, Year) 006 MO person who completed cause of death (Item 23a) (Type, Print) MNNOPPILS BESTOMB 10 900 STANLEY 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 18 2006 Registrar

			1 - For State Registrer	State of Ma	aryland / Depa	artment of F			Reg. No. 200	6 24340
	Physici /Medic Examin	ai	Decedent's Name (First, Middle, Last) Lee Franklin Weddle 4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of D	2. Date of De Month July 25 Death	Day Y	3. Time of Death 8:17 P
	Funeral Director		12635 Mummert Road 5. Social Security Number 215-26-8145	M 2□ F 7. Age	e (In yrs. last birthday) 75 Yrs.	Clear Sp If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bir Min. (Month, Da	y, Year)	ton Birthplace (State or Foreign Country) ryland
	with the Maryland as or 28e-f show the notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Frederick 10e. Street and Number 6411 Fulmer Road		10c. City, Town or Lo	10f. Zip Code			10g. Citizen of Wha	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
5-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene and Mental Hygiene is marked other than "natural", or items 23s or 28e-f ehow aumatic event, the Mudical Examblar must be notified at	ted by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ		lo 16a. Dece	1 ☐ Yes 2 🛣 No	Specify:	? (Specify Yes or No uerto Rican, etc.)	JSA 14. Race - Black, Specify: W	
nd 2	be filed ttal Hygind of other event, t	Be Completed	(Specify only highest grade Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last)	Cottege (1-4or 5	+) /ife.	kind of work done DO NOT use retired	ndant 18. Mother's	Name (First, Middle,		
	is 1 and 2 should of Health and Men Item 27 le marke other traumatic	To	Ira Jacob Weddle 19a. Informant's Name/Relationship (Tyx) Jenny Ellen McVey W	•			and Number o	Mae Fisher r Rural Route Number rederick,	er, City or Town, Sta	ate, Zip Code) 21703
Baltimore,	it. Page rtment c rtant: if njury or		20a. Method of Disposition 1 X Burial 2 Cremation 3 Read Donation 5 Other (Specify) 21. Signature of Funeral Service License		Resthave	matory or other plac n Memoria	1 Garde		20c. Location - Cit	, Maryland
Ba	Deperiment of the control of the con		h. D.	Ger	M00999 1	.06 East (Church	Street, F	rederick,	Funeral Home MD 21701 Approximate Interval Between
	Medical Examiner (the price of the price of	dical Examiner	Immediate Cause (Final disease or condition resulting in death)	Convest Due to (or as Chronic Due to (or as	ive Heart a consequence of): Obstructive a consequence of): a consequence of):	Failure				Onset and Death
P.O. Box 68	The law requires thet the death certificete be executed the hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetat death 3	Ectopic pregnancy Other (specify)	,		23d. Date o Month	f delivery Day Year
ords, P.	w requires thet is been signed by should be detailed	ρ	Part II. Other significant conditions con Hypertension	_	ut not resulting in the u		en in Part I.			ite to the cause of death? Probably 4 □Unknown
tal Rec		e Completed	25. Was case referred to medical				26 Place of		osy prio rmed? dea 2⊠No 1□	e autopsy findings available r to completion of cause of th? Yes 2 No
Division of Vital Records,	ding Phys h. After this funeral di	Certification: To B	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	ospital: 1 Inpatie 28a. Date of Inju (Month, Da)	nt 2 ER/Outpatier y 28b. Time o (Year) Injury	f 28c. Injur Wor	er: 4 🗌 Nursir	ng Home 5 ☐ Resid		SpecifySon's res.
Dix	Hospital or Atten 24 hours after deat Funeral Director: stely filled in by the	I Certifi	4 Homicide determined	building, etc	ury - At home, farm, sti c. (Specify) of my knowledge, deat		ne date and n	City or Tox	vn, State)	or Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check only one) 2 Medical Exemination Medical Exemination (Check only one) 29b. Signature and title of certifier	er: On the basis of and manner sta	examination and/or in ited.	29c. Licens	pinion, death o	occurred at the time,	date and place, and 29d. Date signed (A	due to the cause(s)
)	16		30. Name and address of person who cou	mpleted cause of de		D5463	6		July 26,	2006
*	Sta Registr		Syed W. Haque, MD, 31. Date filed (Month, Day, Year) AUG 0 2 2008	2 Registre	claire Ave	nue, Fred	lerick,	Maryland	21701	

			1 _ State	Maryland / Depa		ealth and M	ental Hygie	ene 2 0 0 6	24341
			Registrar 1. Decedent's Name (First, Middle, Last)			J	2. Date of Death	, No.	3. Time of Death
	Physici	an	Dorothy M. Whitcomb				Month	Day Year	
	/Medic		4a. Facility Name (If not institution, give street and numb	ar)	4b. City, Town, or L		July	26 2006 4c. County of Dea	2:00 A ^M
	Examin	ner	332 Braddock Road Apr		Frost			Allega	
	Consort			Age (In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth		
	Funeral Director		004-26-3829 1□M 2ØF	77 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y) Jan 5,1		thplece (State or Foreign ountry)
			Usual Residence of Decedent		1		van J, i	323 INE	w Jersey
	ylan		10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	Ma-1-	ctor	Maryland Allegany	Frostbu	rg				1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g	. Cîtîzen of What Co	ountry?
	23a	a	332 Braddock Road Apt	404	21532			USA	•
	ams ams	Funeral	11. Marital Status 12. Was Decede Armed Force	ent Ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
0	or it		1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Date	KT No	37	Specify:			Mhite
0-000a	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f ahow palcal Examinat must be nutilised at	d by							
ņ	nat net	lete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	ion iring most of workir	ng 16	b. Kind of Business	Industry
٧		Completed	Elementary/Secondary (0-12) College (1-4	or 5+)	omemaker			OF INT. IION	4 T.
N	Hygie ther int, II		9 17. Father's Name (First, Middle, Last)	110		18. Mother's Name	/First Middle Ma	OWN HOM	15
מבום	ges 1 end 2 should be filed withi t of Heelth and Mental Hygiene. If Itam 27 is marked other than or other traumatic avant, the M	Be	Raymond L. Patterson	1	'		s Mae Re	•	
Š	2 should be and Mental ia marked c	၉	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street ar				Zin Codel
2	d 2 s th an 7 ia trau		Karen Dawson-Daughter		07 McMul				
บ์	1 end Heelth am 27 ther tr		20a. Method of Disposition	20b. Place of Dispo				c. Location - City or	
	Peges nert of I nt: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	cemetery, crei	matory or other place.) [ontown, PA
			4 Donation 5 Other (Specify)				LY 20,20	JOB OILL	ontown, PA
0	Departi Departi Importa any inje		21. Signature of Funeral Service Licensee	Jul.	2. Name and Address Hafer Fur 1302 Nati	neral Se	ervice l	PA ale MD	21502
			23a. Part1. Enter the disease, or complications that cau shock of heart failure. List only one cause on each	sed the death. Do not ent	ter the mode of dying,	such as cardiac o	r respiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition End		Onset and Death				
	/Medical		resulting in death) a. Due to (or	stage representations of the sterior.	04710	4			3 7/1).
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א ס	The law requires that the death certificate tie has been signed by the attending phys age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth		☐Ectopic pregnancy			23d. Date of de	
	dea he at ed fo	sici	1 Yes 2 No 4 Pregnan	t at time of death 5	Other (specify)			Month	Day Year
5	at the by th	ų,	9 🗆 Unknown						
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ecords	w require been si should I	ed	Diabeter nellitur - Ty	per 11			1 Tes	2 2 No 3 □ Pr	obably 4 Unknown
ວ	law re as be 2 sh	Completed	·				24a. Was an autopsy	24b. Were at	stopsy findings available completion of cause of
č	sician: The far certificete has rector, page 2	E					performe	d? death?	22 No
N I G	lan: rtifice	0	25. Was case referred to medical			26. Place of Death			
_	ysic is ce direc	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inp	atient 2 ER/Outpatrer	nt 3 DOA Other	4 ☐ Nursing Hor	ne 5 Residenc	e 6 ☐Other (Spe	cify)
5	nding Physician: th. : After this certifice ; funeral director, p		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month,	njury 28b. Time o Day Year) Injury	f 28c. Injury a Work?	at 2	8d. Describe how	injury occurred	
5	ath. ar: Af	atlo	2 Accident investigation	, , ,,,,,,, .		es 2 No			
	acto by th	ertlflcation:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building	Injury - At home, farm, str., etc. (Specify)	reet, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Ru	ural Route Number.
5	s afte	Cert	Juliania	, etc. (Opecny)			Only or rown, c	States	
	To the Hospitel or Attending Physicien: within 24 hours after death of the Funeral Director. After this certifical completely filled in by the funeral director.	edlcal (29a. Certifier 1 Certifying Physician: To the but (Check only one) 1 Medical Examiner: On the basis and manner	s of examination and/or in	h occurred at the time vestigation, in my opin	, date and place, a nion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	o th	Me	29b. Signature and title of certifier		29c. License	number	29d	. Date signed (Mont	h, Day, Year)
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			30. Name and addreg of person who completed cause	of death (Item 23a) (Type,	Print)	1///		1/2010	0
	6		De Alarie VAMANIA	M) On	Ceton 1)1/ MI	inhow	land IA	1071007
	Sta	ate	31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature	3-1011		ruer	414	V 41300
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Ruth Stella Ward July 14, 2006 1650 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Prince George Hospital Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 15 F 78 579-34-4058 Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Examiner must be notified at D.C. Washington, D. C. 1 XI Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20019 United States 201 58th St. NE. #330 Pages 1 and 2 should be filed within 72 hours after death one of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 💆 Divorced "natural" or than "natura Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Custodial Worker Federal Government other 7 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Lee Harvey CArroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1311 C Street, SE; Apt 31; Washington, Dc. 20003 Angela Byrd/Daughter Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
eny injury or ott 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State July 22, 2006 Cedar Hill Cemetery Suitland, MD. 4 □ Donation 5 □ Other (Specify) Funeral Homes Marlboro Pike 21. Signature of Funeral Sen 22. Name and Address of Facility Forestville, Md. 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examin The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of) Box 68760. by Physician/Medical as attending to for use as 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the all d be detached for 4□Pregnant at time of death 5 Other (specify) o 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 🗌 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy performed? 1 Yes 2 No 1 Yes 2 No of Vital Attending Physician: : After this certification of tuneral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: ↑ ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Division 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No rector: the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Gity or Town, State) in by after 4 Homicide within 24 hours a
To the Funerel C Hospitel 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive; Cheverly, Md. 20785 Gary Little, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 9 2006 Registrar

			For State Registrar	State of Marylan	d / Depa	artment of H	ealth and l	Mental Hy	giene Reg. No.	UUb	24343
4	org May		Decedent's Name (First, Middle, Last,					2. Date of De	eath		3. Time of Death
	Physici		Martha Louise W	dilliams				July	11.	2006	12:35 P.M
	/Medio Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deat		4c. C	County of Death	
			Prince George's	Hospital Cent	er	Chev	verly		Pr	ince Ge	orge's
	Funeral Director		5. Social Security Number 6. Security Number 10	7. Age (In yrs. M 2XF 91	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	9/24/1	rth ay Year) 4	Cou	place (State or Foreign ntry) 'arolina
	p ,		Usual Residence of Decedent 10a, State 10b, County	10c Cit	y, Town or Lo	agation					10d. Inside City Limits
	shov	-	_								1 Serves 2 □ No
	28a-f	Director	Md. P.G. 10e. Street and Number	Ca	pitol	Heights 10f. Zip Code			10g Citiz	en of What Cou	nto/?
	a or		5709 Jost Stree	t		101. Zip 0008	20743	3	109. 01.12	U.S.A.	
	eath	era	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Decedent of H			0- 1-	4. Race - Ameri	can Indian,
136	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. Is marked other then "natural", or Items 23a or 28a-f show aumatic event, Ire Marical Extra intermetable notified at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes ﷺ No	Specify:	to Rican, etc.)		Black, White, Specify: Bl	etc. ack
ָה ה	72 ho	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup kind of work done	during most of wo	rking	16b. Kin	d of Business/Ir	dustry
Maryland 21215-0036	within ane.	mpi	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		DO NOT use retired sekeeper	")		н	otel	
N	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)		1104	Da roop of	18. Mother's Na	me (First, Middle	1		
al	d be ental	o Be	Charles H. Will	iams			Loumi	tia Ina	bnett		
2	Shoul nd Me mark	ဥ	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Street	and Number or Ri	ural Route Numi	ber, City or	Town, State, Zij	Code)
Ξ	nd 2 lith a 27 is		Victoria Jones/Dau	ghter	1091	5 Layton	St. Upp	er Marlb	oro.M	d. 207	74
ē,	s 1 a f Hea ftam ltam othe		20a. Method of Disposition	20b. F	Place of Disponentery, cre	osition (Name of matory or other place	:e)	Date		ation - City or T	
Ę	Page nent o nt: If		1 ☐Burial 2 ☐ Cremation 3 ☐F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State		Mem. Park	17/18	3/06	Lan	dover,	Md_
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licens		2	Name and Addre	no of English	Sons C			D.C. 20019
	ž,		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the deat							Approximate Interval Between
Ĵ	Pnysician		Immediate Cause (Final	Overwhelming	Sensi	C C					Onset and Death
6	/Medical		disease or condition resulting in death)	Due to (or as a conseq					-		
	Examiner		Conventially list conditions	Septic Shock	.2°						
	D ==	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	juence of):						
	and and trans	am	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c. Polybacterial Septicemia 2° Due to (or as a consequence of):								
8760,	cate be executed physician and the burial-transit	dical Ex		Clostridium Perfringens, Staphylococcus and Strepto							us
9	tificat ng ph) as th	ledi									
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-Itansii	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous for the second second for the s	al death 3	Ectopic pregnancy Other (specify)			2:	3d. Date of deliv	ery Day Year
О.	that the	/ Ph	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	ınderiying cause gıv	en in Part I.	23e. Did	tobacco us	se contribute to	he cause of death?
ds,	uires sign	d b	Atrial Fibril	lation				1	Yes 2	No 3□Pro	babły 4 ⊡Unknown
00	w require been sign	lete	Hypertension,	Controlled				24a. Wa	s an	24b. Were aut	opsy findings available
Re	he la e has age 2	μğ	nyper cension,	CONCIONA				per	opsy formed?	death?	mpletion of cause of
ta	ifficat	0	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only		1 🗆 Yes	2 140
>	ysici s cer direct	To B	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Cth	or	Home 5 Res		Other (Speci	fy)
0	Attending Physician: r death. ector: After this certific by the funeral director.		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injur	y at k?	28d. Describe	how injury	occurred	
Ö	ath. or: Ath	atio	2 Accident investigation			ì	Yes 2 □No				
Division of Vital Record	after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special		28f. Location City or To	(Street and own, State)	l Number or Rui	al Route Number,		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C		sician: To the best of my known of the basis of examination and manner stated.							
	within To the comple	Me.	29b. Signature and title of certifier			29c. Licens				signed (Month,	
)	~		> 8/m	\sim		D56	115		Jul	y 12,200	06
	(2)		30. Name and address of person who d	ompleted cause of death (Iter							I It I was
/			Gorgonia Ferrer	,M.D. 3001 Hos	spital	Drive,Ch	everly,	Maryland	2078	35	
		ate	31. Date filed (Month, Day, Year)	2. Registrar's Sign	ature						
FE	Regist		JUL 1 8 2006	there to	Apo	eles .		<u> </u>			
F) -	IMH 17 Rev 1/2	COO1			-						

DHMH 17 Rev 1/2001

			1 = For State Registrar	State of Maryla		artment rtificate				R	eg. No.	2006	243	344
	Physici	an	Decedent's Name (First, Middle, Last)							2. Date of Dea Month	Day	Year	3. Time of	
	/Medic	al		NDSOR		4 63 7			(O + h	07-10-2		2	6:00	A ^M
7	Examin	er	4a. Facility Name (If not institution, give s LAPLATA NURSING			LAPLA		Location of	Death			County of Deat ARLES (
	Euparal		5. Social Security Number 6. Sex		. last birthday)	If Under 1	1 Year	If Under 2	4 Hrs.	8. Date of Birth	1	9. Birtl	hplace (State or	Foreian
	Funeral Director			M 2□F 47	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day 01-07-	1959	Wash	untry)	
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	ocation							10d. Inside Cit	y Limits
	a Mar	ctor	Maryland Prince Ge	eorge's	Brandy	wine							≯₽ Yes	2 🗌 No
	or 28	Directo	10e. Street and Number			10f. Zip (Code			1	0g. Citiz	en of What Co	untry?	
	ath w	la	10505 Cedarville F				206					U.S.A		
	er de Itsm	Funeral	11. Marital Status ★★Never Married 2 Marned	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decede If Yes, speci	ent of His fy Cuban	spanic Orig n, Mexican,	in? (Spe , Puerto F	cify Yes or No- Rican, etc.)	1	 Race - Amer Black, White 		
36	irs aft	by F	3 Widowed 4 Divorced	1 ☐ Yes 2 █ੈੈNo lf Yes, Give Year or Dates:		1 ☐ Yes 💆	No No	Specify:				Specify:	White	
21215-0036	within 72 hours after death with the Maryland ene. Itan "natural", or itams 23a or 28a-f show ita Mudical Exartical minist ke molifikol al	ted	15. Decedent's Educ		16a. Dece	dent's Usual	Occupa	tion			16b. Kin	d of Business/l	Industry	
212	thin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	life.	kind of work DO NOT use	k done di e retired)	uring most	of workin					
	ed wi	Completed	12th		Pa:	inter						-Employ	red	
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene; is marked to ther than "natural", or its marked to ther than "natural", or its marked to the relation and an additional Exact in mental to a rollitied at	To Be	17. Father's Name (First, Middle, Last) Calvert L. Winds	sor						(First, Middle, Smith	Maiden S	Sumame)		
ary	s 1 and 2 should of Health and Men item 27 is marke other traumatic	-	19a. Informant's Name/Relationship (Ty)		19b. Maili	ng Address ((Street al	nd Number	r or Rural	Route Number	, City or	Town, State, Z	(ip Code)	
	and 2 ealth a n 27 is		Wayne Windsor/bro	other	1050	5 Ceda	rvil	lle Ro	d.#1	ot 819	Bran	dywine,	Md. 206	13
ore O	of He		20a. Method of Disposition 1	emoval from State	Place of Dispo cemetery, crei	matory or oth	her place					ation - City or		
Ĕ	Pages ment of ent: if it		4 □Donation 5 □ Other (Specify)	Ce	edar Hi			-		-2006	Suit	land,Ma		
Baltimore,	permit. Pages Depertment of importent: if it any injury or o		21. Signature varial Service License	-mol45	- 0	2. Name and edar H				Pa. Ave	. Su	itland,	20746 Marylan	ıd
	Physician /Medical		23a. Part 1. Enter the disease, or complies shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	dions that caused the deal cause on each line. A T O S Due to (or as a conse	5	ter the mode	of dying	, such as c	cardiac or	respiratory arr	est,		Approximate Interval Betw Onset and D	/een
	ate be executed xx x x x x x x x x x x x x x x x x x	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse										
O. Box 6	st the death certifical by the ettending ph tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yas 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 Live birth 2 Fer 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic pre □ Other (spe					2	3d. Date of deli		ear .
a. D	law requires thet the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying ca	use givei	n in Part I.		23e. Did to	pacco us	e contribute to	the cause of de	ath?
ä	w require been sig should b								_	1 🗆 Y	s 2)	No 3□Pro	obably 4 🗍 U	nknown
Division of Vital Records,	Physician: The law r this certificate has be al director, page 2 sh	Completed							_	24a. Was a autops perform	ned?	prior to c death?	topsy findings a completion of ca	vailable use of
ıta	stan: artifica ctor,	Bec	25. Was case referred to medical examiner?					26. Place	of Death	(Check only on				
<u>></u>	hysic this ce	To	1 ☐ Yes 2 ▼No	ospital: 1 ☐ Inpatient 2				4 W Nur		e 5 Reside			cify)	
on oi	Ter Ter	atlon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28	Bc. Injury Work?	at ? es 2 □ N		8d. Describe h	ow injury	occurred		
	a # in ⊆	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str ify)	reet, factory,	office		2	8f. Location (Si City or Town		Number or Ru	ral Route Numb	Θ <i>Γ</i> ,
	Hospi 4 hou Funer ely fiil	Medical (29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examin	ician: To the best of my kr ier: On the basis of examinand manner stated.	nowledge, death nation and/or in	h occurred a vestigation, i	t the time in my opi	data and inion, death	l placa la h occurre	nd due to the d d at the time, d	ate and p	and manner as place, and due	stated. to the cause(s)	
	To the 2 Within 2 To the 3 complet	Me	29b. Signature and title of certifier			29c.	License	number		2	9d. Date	signed (Month	n, Day, Year)	
		- 1	17. Jun	- M	0	L	155	545	55		7/1	2/0	6	
4.	40	1	30. No ina Hossaino co								1			
	-0-		5625 Allentown Roa 31. Date filed (Month, Day, Year)	32. Registrar's Sign	Spring	g, Mar	ylar	ıd 20	0746					
	Sta Registr		JUL 1 7 2006 A	been to the	horle	•								

			1 - State Registrar	ite of Marylan		rtment of He			iene 2 0 0	6 24345
	Dhuaisi		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	th Day Yea	3. Time of Death
	Physici /Medic		EARL DANIEL WI	NTERSTINI	E			07	21 200	6 5:30AM
	Examin	er	4a. Facility Name (If not institution, give street a	+ Hospi	fal	4b. City, Town, or Lo	berla	nd	4c. County of De	sany
	Funeral Director		5. Social Security Number 6. Sex 1 № M 2	7. Age (In ŷrs. 68	last birthday) Yrs.		f Under 24 Hrs. Hours Min.	(Month, Day	Year)	lirthplece (State or Foreign Country) ST VIRGINIA
	land	1	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Los	cation				10d. Inside City Limits
	Marylan -f ehow Ind at	to	WV MINERAL	R	IDGELE	Y				1 ☐ Yes 2X No
	r 28a	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
	th wit	aiD	ROUTE 2, BOX 333			26753			U.S.A.	
036	urs after dee el', or Rems Extraller in	by Funeral Director	1 Never Married 2 Married 1	as Decedent Ever in U. med Forces?] Yes 2 M No 'es, Give ar or Dates:	l1	Vas Decedent of Hisp Yes, specify Cuban, ☐ Yes 2 ▼ No	anic Origin? (S Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ar Black, W Specify:	nerican Indian, hite, etc. WHITE
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heetit and Mental Hyglene. Important: if Item 27 is marked other than "naturel", or Items 23a or 28a-f ehow entry or other traumatic event. The Modical Examiliar must be muilled at ODGs.	Completed	15. Decedent's Education (Specify only highest grade comp. Elementary/Secondary (0-12) Co	pleted) llege (1-4or 5+)	(Give I	ent's Usual Occupation kind of work done during OO NOT use retired) CK DRIVER	ing most of wor	rking	16b. Kind of Busines KELLY-SPI TIRE COME	RINGFIELD
Maryland 2	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) FRANK CHARLES WINTER	STINE	1	7	8. Mother's Nan	ne (First, Middle, I	Maiden Sumame)	
Mary	nd 2 shouth and h		19a. Informant's Name/Relationship (Type, Pri SHIRLEY WINTERSTINE		1	g Address (Street and				, Zip Code)
Baltimore,	ages 1 au nt of Hee t: If Item r or othe		20a. Method of Disposition 1 ☐ Burial 2本 Cremation 3 ☐ Remova	al from State	Place of Disposemetery, crem	sition (Name of patory or other place)		Date	20c. Location - City	
altin	permit. P Departme Importani eny injury once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Cicensee	/ COM		D CREMATOR	of Facility	25/2006		AND, MD
<u> </u>	80E 8 8		George F. Z	schua)		UPCHURCH P.O. BOX	1260, I	FORT ASH	BY, WV 26	719
	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	_Se	PSI	or the mode of dying,	such as cardiac	or respiratory arri	est,	Approximate Interval Between Onset and Death
	Examiner	L	Sequentially list conditions, b	Due to (or as a consequence to (or as a consequence)	iple	My	elon	Ma		3 years
_	cete be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequ		•				
8760,	icete be e physiciar s the buri		d							
P.O. Box 6	The law requires that the death certific Ne hes been signed by the ettending p page 2 should be detached for use as	Physician/Medicai	in the past 12 months?	res, outcome of pregna Live birth 2 Fetal Pregnant at time of de Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of o	lelivery Day Year
	quires that I n signed by uld be deta	by	Part II. Other significant conditions contribution	ng to death but not resu	ulting in the un	derlying cause given	in Part I.	23e. Did tot	1	to the cause of death? Probably 4 □Unknown
Division of Vital Records,	The law requir te hes been si age 2 should	Completed						24a. Was a autops perfore	y prior t	autopsy findings available o completion of cause of ?
ita	ien: rtifice stor, p	BeC	25. Was case referred to medical			2	6. Place of Dea	ith (Check only on	~	55 2 140
>	hysic his ce I direc	70 5	examiner? 1 ☐ Yes 2 No Hospita	TKI inclationt 2	ER/Outpatient	3□ DOA Other:	4 ☐ Nursing H	ome 5 Reside	nce 6 □Other (Sp	pecify)
ion o	Attending Physicien: or death. ector: Atter this certificaby the funeral director, it		27. Manner of leath 1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 \(\text{Yes}	t s 2 □No	28d. Describe ho	ow injury occurred	
Divis	after des Directo	Certification:	3 Suicide 6 Could not be determined 28e	. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number or o, State)	Rural Route Number,
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: Atter this certificete hy completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 1- Certifying Physician: 2 Medical Examiner: 0 ar	To the best of my kno n the basis of examinat ad manner stated.	wledge, death tion and/or inv	occurred at the time, estigation, in my opini	date and place ion, death occu	, and due to the ca rred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	1010	1	29c. License n	umber	9	9d. Date signed (Mo	nth, Day, Year)
	5		30. Name and address of person who complete	Mawi, A	1 23a) (Type, F	Print)	7117	1	2014	21,2006
	n/sta	to	George Henna	M) MD - 32. Restrar's Signa	925 i	Bl.shop k	lalsh	Rd, Cu	mberlar	10, MD 21562
	Registr		JUL 2 5 2006	Police.	N 4	book				

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JUL 1 9 2006

82. Registrar's Signature

Charles Agbemabiese, M.D. 3001 Hospital Drive; Cheverly, Md. 21785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#20a-22, perfff, G858, 8/11/06, WS

State of Maryland / Department of Health and Mental Hygiene

24347

			1 - Stata Registrar		Cei	rtificate of l	Death	Re	eg. No.	U	_ 707/
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	_	/aar	3. Time of Death
40	Physici /Medio		KEITH A A	NDRUS				07		06	226 PM
1	Examir		4a. Facility Name (If not institution, give s	treet and number)			Location of Death		4c. County of		, , , , , , , , , , , , , , , , , , , ,
1			HOLY CROSS	HOSPIS	SAT	SILVE	R SPRI	NG	MONT	400	VERY
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birthola	ace (State or Foreign
Ю	Director		212-64-3862 18	M 20F 5	Yrs.	Months Days	Hours Min.	12 03	1954	Count	A
	P .		Usual Residence of Decedent								
	how	_	10a. State 10b. County		c. City, Town or Lo					10	d. Inside City Limits
	e Ma	cto	MODTHOM CM	IERY 1	CENSIN	MOTON					1 X Yes 2 □ No
	다 다 0r26	Director	10e. Street and Number			10f. Zip Code	~~	11	0g. Citizen of Wh	at Count	ry?
	th w 23s	a	11137 DEWEY	RD		5080	45		USA		
	dea r	Funeral	11. Marital Status	Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race	- America White, e	
9	72 hours after death with the Maryland "natural", or iteme 23a or 28a-f show dical Exeminar must be notified at		1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1□Yes 2XNo	Specify:	, , , ,	Specify:		
21215-0036	ours iral',	d by	3 ☐ Widowed 4 🗷 Divorced	Year or Dates:					орослу.	7011	1112
5	2 2 2	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done	during most of worki	ng	16b. Kind of Busi	ness/Indi	ustry unk
2	within ene. then *	d u	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	LOYED				
	Hygier ther ti	ပ္ပ	12		SE.	-1 61.11		100			-
Maryland	ild be filed lental Hyg ked othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, N	Maiden Sumame,	UNK	
ya	should nd Men marke imatic	၉									
lar	2 should and Mile mark		19a. Informant's Name/Relationship (Typ		_	-	and Number or Rura	•	City or Town, Si	ate, Zip (Code)
	s 1 and f Health itam 27 other to			HOSPITA			ST GLEN				IC HD SOUR
ore	m O		20a. Method of Disposition 1 ☐ Burial 2 ♣ Cremation 3 ☐ Re	emoval from State		matory`or other plac	(8)		20c. Location - C	,	
Ē	Pages ment of ant: If it ury or o		4 □ Donation 5 ₩ Sther (Specify)			IERAL CHAI		1/2006	BEL AIR	, MAR	YLAND
Baltimore	permit. Page Department of Important: If eny injury of		21. Signature of Euneral Service License	ade Diviec	tor S	2. Name and Addres	ss of Facility EVA	NS CHAPE	L OF ME	MORT	S
ш_	20 E 9 9		May ///	Me	Ba	ltimore,	Mb 21zo.	-8800 HA	REORD R	0312	2/.
н			23a. Part1. Enter the disease, or complice shock, a heart failure. List only on	ations that caused the cause on each line.	death. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arre	est, TID.		merval oetween
-	Physician		Immediate Cours /Cinel		MUCC	BRNIAI	INFA	OITOS	7		Onset and Death
et .	/Medical		resulting in death)	Due to (or as a co			- 1141 141	121101			
	Examiner		Sequentially list conditions b								
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D	be executed sicien and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events								
ó	en af rial-t		resulting in death) Last	Due to (or as a co	insequence of):						
09289	icate be physici s the bu	cal	L d								
	± 0 0	/Medical	reenine T						1	- !	
Вох		1 - 1	230. was decedent pregnant	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐		Ectopic pregnancy	,		23d. Date		
	death on attended for u	Sick	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time		Other (specify)			Mont	n [Day Year
P.0	The law requires that the death ate has been signed by the atter bage 2 should be detached for i	Physicial	9 🗌 Unknown	9□Unknown							· · · · · · · · · · · · · · · · · · ·
	res that igned b	by Р	Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contrib	ute to the	cause of death?
Vital Records,	w require been sig	pa						1 ☐ Ye	s 2 □ No 3	☐ Proba	bly 4 M inknown
ပ္သ	awre	Completed						24a. Was a	n 24b. We	ere autop	sy findings available
Re	The Is ate ha	E						autops: perforn 1 Yes 2	y pri ned? de	or to com ath?	sy findings available pletion of cause of
<u>a</u>		Ö	25. Was case referred to medical				26. Place of Death			Yes 2	No
>	Physician: this certific ral director,	To B	examiner?	ospital:	2 ER/Outpatier	nt 3 DOA Oth	O.F.		nce 6 □Other	/Cnach	
of	Phy or this oral o		27. Manner of Death	28a, Date of Injury	28b. Time o				w injury occurred		
Division	Attending or death. ector: After by the funer	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	pa <i>r)</i> Injury		k? Yes 2 □ No				
isi	Attendar deatl	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	At home, farm, str	eet, factory, office		28f. Location (St	reet and Number	or Rural	Route Nurfiber.
<u>S</u>	after d Direct	Certification;	4 Homicide determined	building, etc. (S	Specify)			City or Town	, State)		1
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b		29a. Certifier 1X Certifying Phys	ician: To the best of m	y knowledge, deat	h occurred at the tin	ne, date and place.	and due to the ca	luse(s) and man	ner as sta	ited.
	Ho 24 h Fui etely	Medical	(Check only 2 Medical Examination)	er: On the basis of exa and manner stated.	amination and/or in	vestigation, in my o	pinion, death occurr	ed at the time, da	ate and place, an	d due to	the cause(s)
	To the within 2 To the complet	₩.	29b. Signature and title of certifier			29c. Licens	e number	25	9d. Date signed ((Month, D	Pay, Year)
	->-0		A HUI I	Lun		102	4348		0	7.7	3-2006
	\		30. Name and address of person who co	moleted cause of death	(Item 23a) (Tuco		, , , 9				-
	/			in the men	4						
	Sta	ite.	31. Date filed (Month, Day, Year)	22 Pagistraria	Cinn Street						
6	Regist		AUG 0 3 2006	Bloom A	Signature Space						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 25. 2006 5:45 A Ju1y Habibeh Bagherzadeh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Casey House 6001 Muncaster Mill Rd. Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2KXF March 16, 1928 Iran 578-21-9821 78 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Exercities Item Letting Land. Maryland Montgomery Bethesda 11 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20816 5101 River Rd. #712 Iran Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Iranian à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Owner Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gholam-Ali Bagherzadeh Mohtaram Bagherzadeh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 400 E. 52nd St. #12C New York, New York Lili Forouraghi (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State National Memorial ParkJuly 28, 2006 Falls Church, VA. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility National Funeral Home 7482 Lee Highway Falls Church, VA. 22042 Δ Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Nonsmall cell lung cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): of Vital Records, P.O. Box 68760, attending physician Certification: To Be Completed by Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Year Day 4☐Pregnant at time of death 5 Other (specify) filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Pother (Specify) H-5 - C 1 ☐ Yes 2 ☑ No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manger of Death Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide Medical 29a. Certifier 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the ! 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mellom H0058032 July 28, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20852 Cynthia M. Williams, D.O. Montgomery Hospice 6001 Muncaster Mill Rd.Rockville, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 0 3 2006 Registrar

			For State Registrar	te of Maryland		irtment of H			Reg. N	$\angle UU$	6	24349
	Physici	-	Decedent's Name (First, Middle, Last) RONALD C. BAKE	R				2. Date of Month			ear	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street a JOHNS HOPKINS BAY	,		4b. City, Town, or BALT	Location of D	eath		c. County of	7 1	N/A
	Funeral Director		5. Social Security Number 6. Sex 13-38-8735	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 h	Ain. (Month	Birth Day, Yea 28,19			ice (State or Foreign y) 71and
poe			Usual Residence of Decedent 10a. State 10b. County		Town or Lo	cation		riay	20,10			d. Inside City Limits
Many a	Sa-f eho	Director	Maryland Baltim	ore	<u>-</u>		Dunda	alk				1 ☐ Yes 2/XNo
ž.	3a or 2		10e. Street and Number 6549 St. Helena Ave	nue		10f. Zip Code	21222)		itizen of Wha ited S		•
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and	ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last)					Name (First, Mic na May				
ary	and Me	Ļ	John Carroll Baker 19a. Informant's Name/Relationship (Type, Print)	nt)	19b. Mailin	g Address (Street a					te, Zip C	Code)
בּ בּר בּי	Health em 27		Maybelle Baker (20a. Method of Disposition	Wife)		St. Hele sition (Name of patory or other place		Date Dund	-	Maryla Location - Cit		21222 n. State
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	hysician		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	that caused the death. e on each line. PNEUMON		er the mode of dyin	g, such as care	diac or respirator	ry arrest,			Approximate nterval Between Donset and Death 2 weeks
	/Medical xaminer			ue to (or as a consequence RENAL FI		E						week
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COLOS, T	an signed b	þ	Part II. Other significant conditions contributin	g to death but not resul	ting in the ur	derlying cause give	en in Part I.			use contribu		cause of death?
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Toth	within To th	Me	29b. Signature and title of certifier	MADA MO		29c. License	number		29d. D.	ate signed (A	fonth, Da	ay, Year)
11	11		30. Name and address of person who complete			Print)				01/2	110	φ
~V	Sta	te	JESSICA COLBURN, MD 31. Date filed (Month, Day, Year)	JHBMC 4 32 Registrar's Signatu	940E1	STERN A	VE, B	ALTIMOR	E, M	212	24	
	Registr		AUG 0 3 2006	32 Registrar's Signatu	Spa	de la						

State of Maryland / Department of Health and Mental Hygiene

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2006 24351

Principles Occided Examine The Following Management of the principles of the princ			1- For State Registrar			Cert	tificate of	Death				F	Reg. No.	<u> </u>		0 11	700
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1.00 1.00			4a. Facility Name (if not institut	tion, give st	treet and num						Death		4c. C	County of	Death		
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2 15-96-4620 XM 2 46 70 10	Funeral		5. Social Security Number	6. Sex	7	. Age (In yrs. la	ist birthday)		_			8. Date of B	irth(MM/DE				or
The State Discussion of December The Control Discussion of Discussion Dis	Director		215-96-4620	1X M	2 F		46 Yrs		Days	Hours	MITT.	Feb 5	, 196	0			Land
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29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	or A or A of the confidence of the confidence of the confidence] <u>i</u>	3 Suicide 6 🗸 C		e 28e. Place	e of Injury - At h	ome, farm, str	eet, factory, o	ffice bu	uilding, et		or Town	, State)				
As Certifier Continued at the time, date and place, and due to the cause(s) and manner as started. Section Continued	pital Ours	l je	4 Homicide								-			_			MD
O.C.M.E. July 9, 2006 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	e Firm			Physicia	n. To the bes	t of my knowled	ige, death occ	urred at the ti	me, da	te and pla	ice, and d	fue to the ca	use(s) and	manner	as start	ed.	
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30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	_	Σ	29b. Signature and title of cer	nier	Λ											ш, рау, Year	,
Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			11 ld	alon	(U)				J.U.N	vi.⊏.			July	ਰ, ∠00	0		
31 Date filed (Month Day Year) 32 Registrar's Signature &					-					- W	D 0455						
State 31. Date filed (Month, Day Year)						17				nore, M	ン 2120	71 					
Registrar AUG U 3 2000 Allaces			13.1.37.	0 3 2	006 32. Re	gistrar's Signat	ure	posti									

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** EANOR CARROLL 5:00 AM /Medical a. Facility Name (If not institution, give street and number) Franklin Square Hosp 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore usedale HOSPHA Il Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 M 2 F Days 218-26-4690 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits ?7 is marked other than "natural", or itsms 23s or 28a-f shov traumatic svant, its Modical Examinat must be notified at 1 Yes 2 No Director UNDALK MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TECHNICIAN NSUPER ISOR MEDICAL K 18. Mother's Name (First, Middle, Maiden Surmame) 17. Father's Name (First, Middle, Last) ·SchLOSSER ပ 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) important: if item 27 is any injury or other trac once. Health a SCHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HANONER, 21. Signature of Fundami Service Licens 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 23a. Part 1. Enter the diseas shock, or heart lailure. . Enter the disease, o complication, or heart lailure. List only that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ara 10 myo /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physicien and for use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? lure 2 M No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: / 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of centitier 29c. License number 29d. Date signed (Month, Day, Year) D0026596 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 31. Date filed (Month, Day, Year) 2. Registrar's Signature State AUG 0 3 2006 Registrar

		·	1 - State On State On State On Postate On Po	of Maryland / Der er FH,G861,L	partment of Health and	Mental Hygier	ne2006	24353
	Physici /Medic		Decedent's Name (First, Middle, Last) SAMUEL	E	BLAUSTEIN	2. Date of Death Month AUGUST	1°, 200°6°	3. Time of Death 2:55 A M
	Examin	200	4a. Facility Name (If not institution, give street and no MILFORD MANOR NURSING H		4b. City, Town, or Location of Deat BALTIMORE	h	4c. County of Death BALTIMORE	
100	Funeral Director		5. Social Security Number 213-30-9877 6. Sex 1 M № 2 □ F	7. Age (In yrs. last birthda 89 Yrs.	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthpl Coun	ace (State or Foreign try) POLAND
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10	Od. Inside City Limits
	the Ma 28a-f s	rector	MD BALTIMORE 10e, Street and Number	BALT	IMORE 10f. Zip Code	10a.	Citizen of What Coun	1 ☐ Yes 2 🕅 No
	ath with	Funeral Director	11 SLADE AVENUE #802		21208	τ	JSA	POLAND
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23s or 28s-f show any injury or other traumatic event, the Medical Exactinal must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Dec Armed F. 1 Yes, G Year or D	orces? 2 🐧 No ve	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer □ Yes 2	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e Specify:	
15-0	in 72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occupation ve kind of work done during most of wo DO NOT use retired)	rking 16b.	. Kind of Business/Ind	ustry
1212	led with lygiene. her thar it, the M		Elementary/Secondary (0-12) College (1-4or 5+) TAIL	.OR		OTHING	
land	uld be fi Aental H rked otl tic ever	To Be	17. Father's Name (First, Middle, Last) NATHAN	BLAU	JSTEIN LEE	me (First, Middle, Maid	en Sumame)	STEINER
, Maryland 21215-0036	and 2 should saith and Mer n 27 is marke iar traumatic		19a. Informant's Name/Relationship (Type, Print) ALFRED WHITEMAN / SON-		iling Address (Street and Number or Ri 2 VALLEY HEIGHTS			
altimore,	Pages 1 annument of Heart of Itam		20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	Siate	rematory`or other place)		Location - City or To	
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service Licensee		22. Name and Address of Facility S 8900 REISTERSTOWN	OL LEVINSON	•	
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	11.			u	Approximate Interval Between Onsey and Death
	Examiner	<u>L</u>	Sequentially list conditions, b.	(or as a consequence of):				
7	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	(or as a consequence or).				
8760,	icate be executed physicien and s the burial-transit	dical Ex	resulting in death) Last Due to	(or as a consequence of):				
P.O. Box 68	The law requires that the death certificate has been signed by the atlending plange 2 should be detached for use as t	Physician/Med	in the past 12 months?	nant at time of death 5	☐ Ectopic pregnancy		23d. Date of deliver	ry Day Year
	w requires that been signed b should be deta	by	Part If, Dther significant conditions contributing to c	eath but not resulting in the	underlying cause given in Part I.	23e. Did tobacc 1 ☐ Yes	ouse contribute to the	e cause of death?
Vital Records,	The law recate has bee page 2 sho	Completed	- the	tension		24a. Was an autopsy performed 1 Yes 2 2	death?	sy findings available apletion of cause of
	Physician: The this certificate har al director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1	Inpatient 2 ☐ ER/Outpati	04	ath (Check only one)	6 □Other (Specify	1
o uc	ding Ph n. After th funeral	lon: T	27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Mor		of 28c. Injury at Work?	28d. Describe how in		<u>, </u>
Division of	Attender death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	e of Injury · At home, farm, sing, etc. (Specify)		28f. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
	To the Hospital or within 24 hours after To the Funaral Dircompletely filled in I	Medical C	(Check only 2 Medical Examiner: On the b	a best of my knowledge, departs of examination and/or ner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	a, and due to the cause urred at the time, date a	(s) and manner as stand place, and due to	ated. the cause(s)
)	To th withir To th comp	Me	29b. Signature and title of certifier	ny	29c. License number	46	SILIO6	Day, Year)
	6		30. Name and address of son who completed fau	tt enras	- 1838 G	rune "	Tree	RA # 30
	Sta Registr		31. Date filed (Month, Day, Year) 32	Registrar's Signature	parte			
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		For State Registrar	State of	iviaryland		artment of H rtificate of L		d Mental Hyg	glene Reg. No. 006	24354
EV.		Decedent's Name (First, Middle,	,					2. Date of Dea Month		3. Time of Death
Physici /Medic			Mildred	Bernice	Coler	nan			29, 2006	5:55P M
Examin		4a. Facility Name (If not institution,				4b. City, Town, or			4c. County of Death	
	14-	Genesis Heritage					Oundall II Under 24		Baltime	
Funeral Director		5. Social Security Number 407-24-3214 Usual Residence of Decedent	1 M 2√5√F	7. Age (In yrs. la 84	Yrs.	Months Days		Min. (Month, Da)		place (State or Foreign ntry) ntucky
land Dw		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
Many -f sh	tor	Maryland	Baltimor	e		Esse	<			1 ☐ Yes ¾ ∭No
within 72 hours after death with the Maryland jiene. r than "naturel", or Items 23e or 28e-f show Ite Madical Examiner must be nutified at	I Director	10e. Street and Number 310 Riverside	Drive			10f. Zip Code	21221		10g. Citizen ol What Cou United Sta	
death	nera	11. Marital Status	12. Was Dece Amed For	dent Ever in U.S	S. 13.	Was Decedent of Hi	spanic Origin	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ameri Black, White	
s after , or Ito smins	by Funeral	1 Never Married 2 Marrie	d 1 ☐ Yes If Yes, Giv	M∑No e	į	1 ☐ Yes 🎞 No			Specify:	White
ture!		3 XWidowed 4 ☐ Divorced 15. Decedent's	Year or Da	ates:	16a Dece	dent's Usual Occupa	ation		16b. Kind of Business/Ir	
in 72 in 72 fedic	Completed	(Specify only highest	grade completed)		(Give	kind of work done of DO NOT use retired	furing most of	working	Tob. Kind of Businessyn	idustry
77 75 14 14	mo	Elementary/Secondary (0-12) 12 Years	College (1	-4or 5+)	Hon	emaker			Own Home	9
be filed tal Hygie d other	BeC	17. Father's Name (First, Middle, La	ist)				18. Mother's	Name (First, Middle,	Maiden Sumame) [Jkn.
	To		C	herry						
2 6 8 1		19a. Informant's Name/Relationship		(Con)					r, City or Town, State, Zi ore, Marylan	
s 1 and 2 f Health item 27 other tra		Carroll C. Coler	an, III			-	1102 250	Date	20c. Location - City or T	
e = 5		1X Burial 2 Cremation 3				sition (Name of matory or other plac		8/3/2006		
permit. Par Deportment Important: any injury once.		Donation 5 ☐ Other (Special Service Lie		Sac						
permit. Deportmine Imports any inju		100.		a	1	Juda-Ruck	Funera	al Home of Dundalk, N	Dundalk, I Maryland 21	nc. 222
		23a. Part1 Enter the disease, or or	omplications that ca	aused the death.		200				Approximate
Pnysician		enock, or heart failure. List or Immediate Cause (Final disease or condition	CERE	BROY	VASO	CULAR	ACC	-1 DEN	1 0	Interval Between Oriset and Death
/Medical		resulting in death)	a	or as a consequ	ence ol):	. 118	DE	7		
Examiner		Sequentially list conditions.	b. <u>F</u>	SEN	TIA	LH	TIE	CIENS	10N 1	STEAR
p tis	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):					,
xecut and Il-tran	Examiner	that initiated events resulting in death) Last	c	or as a consequ	ence ol):					
ate be executed hysician and he burial-transit	cai E									
ificate g phy as the			u.							
The law requires that the death certification has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		come of pregnar		Ectopic pregnancy			23d. Date of deliv	,
death	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No		ant at time of de		Other (specify)			Month	Day Year
at the de d by the a etached	Phy	9 Unknown						an Div		
res tha signed I be del	ρ	Part II. Dther significant condition	s contributing to de	eath but not resu	iting in the u	nderlying cause give	en in Part I.	23e. Dia to	obacco use contribute to t es 2 No 3 □ Pro	bably 4 Unknown
v require been si should l	Completed				* **		•			
: The law cete has t page 2 s	mpi							- 24a. Was a autop	sy prior to co	opsy lindings available ompletion of cause of
ician: Th certificete rector, pag								perfor 1□ Yes	2 No 1 ☐ Yes	2 □ No
) Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No	Hospital:	tit 2	D/Outpatie	Othe		Beath (Check only or		
Phys rrthis aral di	. To	27. Manner of Death			P/Outpatie 28b. Time o	28c. Injury	at		ence 6 Other (Speci	(Y)
nding Ph th. :: After thi e funeral	atior	1 Natural 5 Pending 2 Accident investiga		h, Day Year)	Injury	Work	(? Yes 2 □ No			
Attendi r death. ector: A by the fu	HICE	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place	of Injury - At hor	me, farm, st	eet, lactory, office		28f. Location (S City or Tow	Street and Number or Run	al Route Number,
tal or rs afte el Dir ed in	Certification:	4 Hornicide	Dullali	ig, etc. (Specify)	, 			City of You	n, Slate)	
To the Hospital or Attending within 24 hours after death. To the Fur erel Director: After completely filled in by the fune	Medical	29a. Certifier 1 Certifying 2 Medicel Example 1	Physician: To the caminer: On the ba and mann	asis of examinati	vledge, deat on and/or in	h occurred at the tim vestigation, in my op	e, date and p pinion, death o	lace, and due to the o occurred at the time, o	cause(s) and manner as s date and place, and due t	stated. o the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	· of			29c. License	number		29d. Date signed (Month,	Day, Year)
X		Horyan	mgh	I.M-	>.	7	1416	0 1	VLY 29, 2	_006
2		30. Name a state essiphperson w	no Sortingle de la	e et deale Hem	23a) (Tyg	ecinty 0-A	RIT	CHIEFI	GHWAY	BALTIMOR
2	***	31. Date filed (Month, Day, Year)	32. R	egistrar's Signati	ure	MA	+70	HND 2	(245	
Sta Registi		AUG 0 3	2000							
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			1 - State Amend item#28		of Mar E,g858	yland / Depa ,8/19/06 dT,	artment of I	lealth ar Death	nd Mental Hy	giene Reg. No.	2006	24355
	Physici		Decedent's Name (First, Middle	· ·	Thom	as Cloude	<u>.</u>		2. Date of De Month July	ath Day	Year	3. Time of Death
-	/Medio		4a. Fecility Name (If not institution				4b. City, Town, o			1	County of Death	
			53 Craig Court		t =		Conow		U-a 1		ecil Co	
	Funeral Director		5. Social Security Number 215–17–5628	6. Sex 1 ★ 2 ☐ F	7. Age (/ 23	n yrs. last birthday) Yrs.	Il Under 1 Year Months Days		Min. 8. Date of Bi (Month, Di June 1.	ay, Year)	Co	hplace (State or Foreign untry) Cyland
	yland		Usuel Residence of Decedent 10a. State 10b. County		10	Oc. City, Town or Lo						10d. Inside City Limits
	death with the Maryland me 23a or 28a-f show rmust be notified at	Director	Maryland (Cecil			COT	owingo		10a. Citiz	zen of What Co	1 ☐ Yes 22 ☐ No
	h with		53 Craig Cou	ct				21918			United	•
2	n 72 hours after death with the Marylan "naturel", or (teme 23e or 28e-1 ahow solicel Exercites mast be notified at	by Funeral	11. Marital Status XXNever Married 2☐ Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was De Armed F 1 Tyes if Yes, G Year or	orces? 2020No ive	4	Was Decedent of It f Yes, specify Cub		n? (Specify Yes or No Puerto Rican, etc.)		14. Race - Ame Black, White Specify:	
200-0	within 72 hours after ene. than "natural", or Ita		15. Deceden (Specify only highes	t's Education		16a. Dece (Give	tent's Usual Occup kind of work done DO NOT use retire	pation during most of	f working		nd of Business/I	Industry
717	d withir giene.	Completed	Elementary/Secondary (0-12) 12 Years	College	(1-4or 5+)	ı			Salesperso	1	ctrical and Sa	
200	d be filed ental Hygi ced other c avent, I	Be	17. Father's Name (First, Middle, Edward Keitl	,				18. Mother's	Name <i>(First, Middle</i> Linda Dai			
lal y	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 's mary injury or other traumatic avent, Item and none.	₽ P	19a. Informant's Name/Relations	hip (Type, Print)) (- -				or Rural Route Numb	er, City or	r Town, State, Z	
C,	s 1 and f Health item 27 other tr		Mrs. Linda D. 20a. Method of Disposition	Cloude (20b. Place of Dispo			wingo, Mai		nd 2191 cation - City or 1	
altillo	Pages tment or tent: If ury or		1 🔀 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (9)	becity)	1	Mt. Zion	Church	7	/31/2006	Lur	ay, VA	
Da	permit Depar Impor any in		21. Signature of Funda Seguide	Lice see			uda-Ruck	Funera	al Home of Dundalk,			nc. 1222
			23a. Part1. Enter the discase, or shock, or leart failure. List	mplications that only one cause on	caused the						rand 2	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. A.5	br as a	exiction onsequence of):					-	Ifiate
	Examiner	- Per	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Ha	-sin	nsequence of):						Indite
	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.								
500	cate be executed physician and the burial-transit	dical E	3 , 2-2.	d	(or as a c	ansequence of):						
00 40	certifica nding ph use as th	lan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	ulcome of p	oregnancy					23d. Date of deli	MAD!
2	e law requires that the death certifi has been signed by the attending p ye 2 should be detached for use as	Physician	in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live	birth 2 nani at tim	Fetel death 3	Ectopic pregnancy Other (specify)	/			Month	Day Year
, (2)	The law requires that the ate has been signed by th bage 2 should be detache	ρ	Part II. Other significant condition	ens contributing to	death but n	ot resulting in the u	nderlying cause giv	ren in Part I.				the cause of death?
	aw requisible been 2 should	Completed							24a. Was	an	24b. Were aut	topsy findings available
	n: The licate har, page								auto perfo 1 Yes	omed? 2/2 No	death?	ompletion of cause of
ואוומו	ysician iis certii directo	To Be	25. Was case referred to medical examiner?1 X Yes 2 □ No	Hospital:	Inpatient	2 ER/Outpatien	t 3□ DOA O#	ec	ng Home 5 Resi	-	G □Other (Spec	ufy)
	To the Hospital or Attending Physicien: The Within 24 hours after death. To the Funeral Director: After this certificate his complately filled in by the funeral director, page		27. Manner of Death 1 □ Natural 5 □ Pendin 2 □ Accident investig	9	of Injury oth, Day Yo	100 1	515 Wo	y at k? Yes 2 No	28d. Describe Subject		occurred	10
[A 2	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A complately filled in by the fu	Certification:	3 Suicide 6 Could i	not be 28e. Place		- Al home, larm, str	OH-		28f. Location (City or To	Street and wn, State)	d Number or Ru	ral Route Number,
3	papital hours a ineral D y filled i		29a. Certifier 1 ☐ Certifyin	g Physician: To th	e best of n	ny knowledge, death	occurred at the tir	ne, date and p	place, and due to the	cause(s)	and manner as	stated.
	To the Hospital or within 24 hours afte To the Funeral Dir complately filled in	Medical	(Check only one) 2 Medical 29b. Signature and title of certifier	and ma	ner stated	amination and/or inv	estigation, in my o		occurred at the time,		place, and due e signed (Month	
	F 3 F 8		M. Fark	is, r	17		214	7314	4		28, 1	
	21		30. Name and address of person	who completed cau	se of deat	h (Item 23a) (Type,	Print)	Elleta	داس ب			
	Sta		31. Date filed (Month, Day, Year)	006	Registrar's	Signature	des .	- //(10	קות, ה			
	Registr	dľ	HOU V J L	1000		10						

		1	For State Registrar		f Marylar	nd / Depa	artmer	nt of H			-		2000	24	355
	sician		Decedent's Name (First, Middle, Last Van Campbell)							2. Date of D Month July	eath Da	2006	3. Time o	f Death
	edica miner	4	a. Facility Name (If not institution, give Mariner Health of Social Security Number 6. Se	Glen B		last birthday)	If Unde	G1 r 1 Year	en Bi	urnie 24 Hrs.	8. Date of B	irth	Anne Aru		or Foreign
Direct	or	I	Jsuel Residence of Decedent	M 2□F	92	Yrs.	Months	Days	Hours	Min.	April	18	1914 AĨ	abama	
death with the Maryland me 23a or 28a-f ehow	ţ		Maryland Anne Ai	undel	10c. Ci	ty, Town or Lo	nove								2 No
h with th	Dire	1	ide. Street and Number 1448 Fairbanks Dr:	ve			10f. Zi	o Code	210	076		_	itizen of What Co nites St		
Mary idition (17.13-0030) 2 should be filed within 72 hours after death with the Marylan 3 and Mental Hygiene 7 fe marked other then "natural", or Iteme 23a or 28a-f show reumatic event. If a Modical Examination or publish	by Emeral Director	5	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Dec Armed Fo 1 X Yes If Yes, Gir Year or D	2 No		Was Dece If Yes, spe 1 Yes		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto f	cify Yes or N Rican, etc.)	0-	14. Rece - Ame Black, Whit Specify:		
ary tarto Z 1 Z 15-0050 should be filed within 72 hours after and Mental hygiene, marked other then "natural", or fite umatic event, the Modical Examina	Completed	- Indiana	15. Decedent's Edit (Specify only highest grade (Specify only highest grade (O-12) 12	cation le <i>completed)</i> College (1-4or 5+)	16a. Dece (Give life.	kind of w DO NOT	ork done d ise retired	turina mos		ng		Kind of Business	•	t &
YIZING A build be filed: Mental Hygis arked other	ToBe		17. Father's Name (First, Middle, Last) Willie Campbe	.1					18. Mothe	ers Name	(First, Middle ne Tate	2	n Sumame)		
0			19a. Informant's Name/Relationship (T) Carol J. Jackson		er							-	or Town, State, 2 D 21076	Zip Code)	
Dalkimore, permit. Pages 1 an Department of Heal Importent: if item eny injury or other		2	20a. Method of Disposition 1 XBurial 2 Cremation 3 1 4 Donation 5 Other (Specify,	Removal from	20h I	Place of Dispo cemetery, crei hseman d Crema	sition (Na	me of			ate 7,	20c. t	ocation - City or Detroit,		gan
Daltimor permit. Pages Department of I Importent: If its	Suc		21. Signature of Funeral Service Licens	amo	dep	22	Name a	nd Addres	s of Facilit	al Ho Road,	me & (Odent	Crema	atory, P MD 2111	4 ^A .	
Pnysici	an j		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on e	caused the dear			de of dyin	g, such as	cardiac o	r respiratory	arrest,		Approxima Interval Be Onset and	tween
/Medic Examin	ier		resulting in death) Sequentially list conditions,	b. A1	or as a consec zheimen	's Dem	enti	a							
BOX 68/60, eath certificate be executed attending physicien and for use as the buriat-transit		Cal LAg	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec										
the death certificate y the attending physiched for use as the	Della cicional	lysicial unio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live t	tcome of pregn oirth 2 Teta nant at time of c	al death 3	⊒Ectopic p ⊒ Other (s	oregnancy pecify)					23d. Date of del Month		Year
S, T, es that es that be detailed be detailed be detailed be detailed by the d		2	Part II. Dther significent conditions co Diabetes Mellitus		eath but not res	sulting in the u	nderlying	cause give	en in Part I		1		use contribute to		death? Unknown
The law ate has b	200	Complete	Hypertension									s an opsy formed? 2 🐼 N	prior to death?	utopsy findings completion of	available cause of
VICA sician: certific	á	ם ס	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:	Inpatient 2] ER/Outpatier	nt 3□ D	OA Dth			<i>(Check only</i> me 5 □ Res		6 ☐Other (Spe	cify)	
- pr in a			27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date (Mon		28b. Time o Injury		28c. Injun Worl		2	28d. Describe			,,	
Dr. Airec			3 Suicide 6 Could not be 4 Homicide determined	build	of Injury - At h ing, etc. (Speci	ify)					City or To	own, Sta			nber,
Hospitel (24 hours a Funeral C	(10)	Medical	29a. Certifier 1 Certifying Phyone) 1 Medical Exem	iner: On the b	e best of my kn easis of examination stated.	owledge, deat ation and/or in	h occurre vestigatio	at the time n, in my or	ne, date an pinion, dea	nd place, a th occurre	and due to the ed at the time	e cause(, date ar	s) and manner as nd place, and due	stated. to the cause(s)
To th To th		2	29b. Signature and title of certifier	ni wa	15			c. Licensi	is ZZO				ate signed (Mont		
241			30. Name and address of person who o				Print)						ıly 31,	2006	
L\	CA		Mahesh Ochaney	32	spital Registrar's Sign	ature			Gler	Bur	n i e, M	D 21	.061		
Reg	State gistra	r	31. Date filed (Month, Cay, Year) 20	16	ر مستن	J. An	and a	,							

			Please Type of Print in Black Indelible ink. Ensure A		
			State of Maryland / Department of Health and N	Mental Hygie	ene 006 24357
			1 - State Registrar Certificate of Death	Reg	. No.
	sicia		1. Decedent's Name (First, Middle, Last) Ann R Civaria	2. Date of Death Month	Day Year Z. 2006 Z. 200M
	ledic amin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
			306 Cantata Ct Apt 407 Preistersta	· · · · · · · · · · · · · · · · · · ·	MD
Fune Direc			5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birthplace (State or Foreign Country) 5 4
pue *			Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location		10d. Inside City Limits
/anyla		ō	MD Baltimore Reisterstaum		1 ☐ Yes 2 No
the 1		ect	10e. Street and Number 10f. Zip Code	10a	. Citizen of What Country?
I Z I 3-0030 within 72 hours after deeth with the Maryland ene. than "natural", or Iteme 23a or 28a-f ehow	200	Funeral Director	306 cantata Ct Apt 407 21136		USA
deeti me 2		Jer	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spanish Status 13. Was Decedent of Hispanic Origin?)	pecify Yes or No-	14. Race - American Indian,
o after		Ē	Armed Forces? Mever Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	o nican, etc.)	Black, White, etc.
ours l'isin	9	d by	Year or Dates:		Specify: Black
n 72 h		Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of won life. DO NOT use retired)	king 16	b. Kind of Business/Industry
id A 12 e filed within Il Hygiene. other then		дшо	College (1-4or 5+) Physical Therapy Assi	+. 9	atterson Home
filed with Hygiene other the	1	Ö		ne (First, Middle, Ma.	
y car		ToB	Pearl	Brite	
2 should be and Mental		-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	ral Route Number, C	
Deficiency INC permit. Peges 1 and 2 Department of Health a Important: If Item 27 is	otner traumatic event, in a madical		Darrel Clark / Son 2720 Bedeon Dr. Edg	ewad mi	21040
S 1 S T S T S T S T S T S T S T S T S T			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	c. Location - City or Town, State
Peges ment of ant: If It	, ,		4 Donation 5 Other (Specify)	106 mi	dde River (m)
Dermit.	eny in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility (eene functual service
4 a a a	a		Mayin C. Gue		town, MD 21133
			23a. Part1. Entel the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest	Approximate Interval Between Onset and Death
Physic			Immediate Cause (Final disease or condition resulting in death)	1 215	SIZ A J IZ
/Medi Examii			resulting in death) Due to (or as a consequence of):		
		-	Sequentially list conditions, if any, leading to minediate Due to (or as a consequence of).		
B /0/	2	nlne	cause. Enter Underlying Cause (Disease or injury		
be executed	al-Ira	Examiner	that initiated events c		
te be executed ysicien and	Una 6	cal	4		
ifficat of physical	as III	edi		72	
th cer	esn.	an/N	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death 3□Ectopic pregnancy		23d. Date of delivery
e dea	9	Physician/Medi	1 Tyes 2 BNo 4 Pregnant at time of death 5 Other (specify)		Month Day Year
d by t	eracu	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23a Did tohac	co use contribute to the cause of death?
signe		d by	Fat it. Other significant conditions contributing to death out not resulting in the underlying cause given in Fat it.		2 □ No 3 □ Probably 4 ⊠Unknown
reque peen	nous	etec		240 1400 00	24h Mara autana findinan auslahla
ne lav	2 86	ompleted		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
in T	or, pa	Co	25. Was case referred to medical 26. Place of Dea	1 ☐ Yes 2 €	No 1 Yes 2 No
s cert	JIL BCI	0	examiner?		e 6 □Other (Specify)
2 E E	eral	i i	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how	
ath.	5	atio	1 ☑ Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No		
r Atte	à l	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
urs aff	De .	Š			
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funciel Director: After this certificate has been signed by the ettending phys	atery t	edicai	29a. Certifier (Check only one) 1 Semifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the caus rred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
o the	dwo	Me	29b. Signature and title of certifier 29c. License number	29d	. Date signed (Month, Day, Year)
FSF	ر) (in _ K.S. NAO, TIO D43462	1	160ST 2, 2006
1	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - 5 - 10 - 5	20.	
	'\		5400 010 COUNT NO #108 NAMOALLITE	y was	051133
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		
Re	gistr	ar	AUG 0 3 2006		

			For State Registrar	State of Marylar	nd / Depa	artmer	nt of H	ealth and Death		ital Hyg	jiene	006	24358
	Physicia	an	Decedent's Name (First, Middle, Last)	Nannie	В.		Dula	าว่		Date of Dea Month	th Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give :			,		Location of Dea	ath	ULY	51	2006 county of Dear	
	Examin	er	Union Memorial Ho			40. Oily		cimore (40. 0	N/A	
Ī	Funeral		5. Social Security Number 6. Sex	M argre	last birthday) Yrs.	If Unde Months	r 1 Year	If Under 24 Hi	rs. 8. i	Date of Birth Month, Day			thplace (State or Foreign buntry)
	Director		225-30-0882 Usual Residence of Decedent	80					N	ov. 5	1925	Vir	ginia
	Marylar f ehow	ō	10a. State 10b. County Maryland Balt	imore 10c. Ci	ty, Town or Lo	cation	Dund	la1k					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	or 28a	Director	10e. Street and Number			10f. Zij	p Code				0g. Citize	en of Whal Co	ountry?
	s 23e		7607 South Bend R		10			21222				ted St	
220	hours after death with the Maryland tural, or Items 23a or 28a-f ehow al Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:				spanic Origin? (n, Mexican, Pue Specify:	(Specify erto Rica	resorno- in, etc.)	-	I. Race - Ame Black, Whit pecify:	
9500-617	"natural", adicel Exp	Completed by	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece	dent's Usu	al Occupa	ation luring most of w	vorking		16b. Kind	d of Business	
	withir ene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		omem.		,				Own Ho	nme
D	e filed al Hygi other vent, II	BeC	12 Years 17. Father's Name (First, Middle, Last)		1	iomem.	axer	18. Mother's N	lame (Fi	rst, Middle,	Maiden S		ALC .
yiand	ould b Menta Marked Marked	2	Ellis W. Prito								3irkh		
Mar	d 2 shou th and M 7 is mar treumati		19a. Informant's Name/Relationship (Ty) Mr. John Dula;	pe, Print) (Son)		-		<i>nd Number or I</i> ad Road				Town, State, I Cyland	Zip Code) 21222
d)	Heal Heal		20a. Method of Disposition	5.000	Place of Dispo				Date	-		ation - City or	
Ê	Page nent o nrt: If ury or		1X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State				ox Cem	. 8/	3/2006	5 E	altimo	ore, Maryland
baltimore,	permit. Pages Department of the importent: If ite any injury or ot once.		21. Signature of Funeral Service License		22	Name a Duda	nd Addres	s of Facility Funera Ave.	al H	ome of	Dur	dalk,	
	Physician	Fel	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	calions that caused the dealer cause on each line.			_	y, such as cardi					Approximate Interval Between Onset and Death 5 YEARS
	/Medical Examiner	_		Due to (or as a consec URONI Due to (or as a consec	CRE	NA	L	NSUF	101	ENC	X		5 YEARS
	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that iniliated events resulting in death) Las!	SEPTIC	SHO	CK							1 WEEK
=	e ys	cal	Tooland in County East	Due to (or as a consec	quence or):								
DOX.	it the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 m/onths? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3]Ectopic p] Other (s)					23	d. Date of dei Month	ivery Day Year
'n, T	es tha gned be de	Ď	Part II. Other significant conditions cor	tributing to death but not res	sulting in the u	nderlying (cause give	n in Part I.			bacco use		the cause of death?
Hec	The law ete hes b page 2 sl	Completed							-	24a. Was a autops perform	ijγ	24b. Were au prior to death? 1 \(\sum \text{Yes}\)	utopsy findings available completion of cause of
VII	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		_	Othe	26. Place of D					
	Physic this stal dii	. To	1 ☐ Yes 2 Mo 27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of		28c. Injury Work	at Nursing		5 Reside			cify)
0	Attending F r death. octor: After by the funera	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м		? ⁄es 2 □ No					
	F 0 F 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Al h building, etc. (Speci	ome, farm, str fy)	eet, factor	y, office			Location (Si City or Town		Number or Ru	ural Route Number,
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	Medical (29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of my knoter: On the basis of examination and manner stated.	owledge, death ation and/or in	vestigation	n, in my op	inion, death oc	ce, and curred a	due to the c t the time, d	ause(s) a ate and p	nd manner as lace, and due	stated. to the cause(s)
	To the within To the compl	≥	29b. Signature and title of certifier			P		13894		3	uly		1006
6)		30. Name and address of person who co DRAGANA TOMIC, MD			Print) SPITA	+L, 2C) I EAST	UNI	UERSI	TY P	ARKWA	Y, BALTIMORE
~ ,	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 3 2006	32. Registrar's Sign	ature La	1/2)							

			1 - For State Registrar	e of Maryland / Dep <i>Ce</i>	artment of F rtificate of			ene a. No. 2006	24359
	Physici		1. Decedent's Name (First, Middle, Last) Barbara		Doel	110	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street at 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last birthday)	4b. City, Town, o	If Under 24 Hr Hours Mir	E CIA	4c. County of Deat N Year) 9. Birt Co	
	yland 10w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		11011 - 1		10d. Inside City Limits
	the Mar	ector	Maryland Baltimos	e	104 71: 00-10	Dundal		0.00	1 □ Yes 🗶 No
	23a or	Funeral Director	6932 Broening Road		10f. Zip Code	21222		g. Citizen of What Co United St	
136	hours after death with the Maryland Lurel', or Items 23a or 28a-f show al Examinar must be notified at	by Fune	1 Never Married 2 Married 1 If Ye	ed Forces? Yes 2 2 No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White Specify:	
1215-0036	within 72 hours ene. then "naturel", the Madical Ext	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle	16a. Dece (Give life.	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wi	orking 1	6b. Kind of Business/	
ק ק	filed Hygi other ent,	Be Col	10 Years 17. Father's Name (First, Middle, Last)	Home	emaker	18. Mother's Na	ame (First, Middle, M	Own Home daiden Sumame)	<u> </u>
ryland	should be and Mental a marked c umatic eve	ToB	Kenneth Lee Andrews 19a. Informant's Name/Relationship (Type, Prin		- Add- (Canada		ra Rose Tu		
Ma	tre tre						Dundalk,	City or Town, State, 2 Maryland	21222
more,			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal	from State	matory or other plac	1		0c. Location - City or	
Baltin	permit. Pages 1 Department of H important: if ite any injury or ott		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Hilltop 9	2. Name and Addres	ss of Facility	/31/2006 Home of D	Towson, M undalk, In	
u	7073 g d		23a. Part 1. Enter the disease, or complications	that caused the death. Do not ent	222 Wise 2	Ave. Du	indalk, Ma:	ryland 21	222 Approximate
	Physician /Medical		Immediate Cause (Final disease or condition essulting in death)	Septic	shock	-			Interval Between Onset and Death
	Examiner	_	Sequentially list conditions.	Backtola	pecli	bon/ti-	5		72 hours
'n	icate be executed physicien and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Abdaning (e to (or as a consequence of):	Wound	1 6	Pehiscen	ce	2 months
09/89	ificate be g physicie as the bu	edicai	d	Ascites					3 months
O. BOX	w requires that the daath certif been signed by the attending should be detached for use a:	Physician/M	in the past 12 months?		□Ectopic pregnancy □ Other (specify)			23d. Date of deli	very Day Year
cords, P	The law requires thet the site has been signed by the page 2 should be detached.	þ	Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
	8 8 8	Completed				· · · · · · · · · · · · · · · · · · ·	24a. Was an autopsy performe 1 \(\text{Yes} \) 25	prior to c death?	topsy findings available completion of cause of 2 No
<u> </u>	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) Hospital:	1 Minpatient 2 ☐ ER/Outpatier	nt 3 DOA Othe	20	eath (Check only one)) ce 6 □Other (Spec	n(hc)
VISION OF	To the Hospitel or Attending Physician: The is within 24 hours after death. To the Funeral birector: After this certificate he completely filled in by the funeral director, page.		2 Accident investigation	Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury Work		28d. Describe how		ay)
	tel or Att rs aftar d ai Direct ed in by t	Certifications	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, stroulding, etc. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completaly filled in by the fune.	edicai	Check only 2 Medical Examiner: On	o the best of my knowledge, death the basis of examination and/or in- manner stated.	h occurred at the tim vestigation, in my op	ne, date and plac pinion, death occ	e, and due to the cau surred at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To t	Σ	29b. Signature and title of certifier		29c. License	number	290	d. Date signed (Month	,
	51	-	30. Name and address of person who completed			5-00	0 4	44 25	1 21224
	Sta	te.	Santosh Oommen 31. Date filed (Month, Day, Year)	1940 Eastern 32. Registrar's Signature	Avenue	1 /5	altimere,	Marylea	1 21224
	Registr		AUG 0 3 2006	Million It A	market)			·	

		•	For State Registrar	State	of Marylar			of Health of Death			giene Reg. No.	2006	24360
	Dhysisi		1. Decedent's Name (First, Middle,	Last)		-				2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Charles C.	Diggs	Jr.					July	31	2006	2:20 P ^M
	Examin	er	4a. Facility Name (If not institution,		number)			vn, or Location	of Death		4c.	County of Deal	
			10821 Greenvi	-	1			umbia	- 0.4 Mag			Howard	
	Funeral Director		218-52-1565	5.Sex 1 2X M 2 □ F	7. Age (In yrs. 58	Yrs.	If Under 1 Y Months D	ays Hours	Min.	8. Date of Bird (Month, Da Oct. 10	y, Year)	9. Bin Co Ma:	thplace (State or Foreign ountry) ryland
-	*_		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
Asrol	P .	ō	Maryland Howar	-7		Colum	ai a						1 ☐ Yes 2 🖪 No
Į.	288	Director	10e. Street and Number	.u		COLUM	10f. Zip Co	de			10a, Citiz	zen of What Co	ountry?
prepared at the theorem	P o		10821 Greenview	. Wav				21044				U.S.A.	,
die al	ns 2,	Funeral	11. Marital Status	12. Was De	cedent Ever in U	l.S. 13. \	Vas Decedeni	of Hispanic O	rigin? (Spe	cify Yes or No		4. Race - Ame	nican Indian,
0	-	표	1 ☐ Never Married 2 ☐ Marrie	Armed I d 1 □ Yes	2 No		Yes, specify	Cuban, Mexica	an, Puerto l	Rican, etc.)		Black, Whit	_
3	L.	þ	3 ☐ Widowed 4 🔀 Divorced	If Yes, C Year or	ive		I□Yes 202	No Specify	y:			Specify: Who	ite
ה ה ה	lical	ted	15. Decedent's	Education	d)	16a. Deced	lent's Usual C	ccupation	st of workii	30	16b. Kir	nd of Business	Industry
1		ğ	Elementary/Secondary (0-12)	College	(1-4or 5+)	Direc	ONOT USE T	one during mo State OCACY	and	.9		111 0	
d Z I Z I 3-0030	ygier t, t	Completed		8+		Consu	ner Adt					lth Sei	rvices
		Be	17. Father's Name (First, Middle, L					100	_	(First, Middle,		Sumame)	
aryian should be	Men varke	5 P	Charles Claytor							Rosomer			
-	h and 7 le m rraum		19a. Informant's Name/Relationsh									Town, State, 2	
ຂຸ້.	Health tom 27 other tr		Jayne Diggs ()	(-wife)	20b. F	Place of Dispo	sition (Name	of		LUMDia,		yland 2	
	or or or		1 ⊠Burial 2 ☐ Cremation		m State Me	emetery, crer adowrio rk	ige Men	orial	0.7	2006		,	
	ntani njun		4 □Donation 5 □ Other (Sp 21. Signature of Funeral Service L		Pa				8-7-		EIKT	iage, N	Maryland
ם פ	Department of Healt important: If item 2 eny injury or other once.		Mo C. Ho	Va-	_	M.	tzke F	uneral n Knol	Home	s, Inc.	ımbi	a Mars	land 21045
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	omplications that	t caused the deat							a, mar	Approximate
ь	hysician		Immediate Cause (Final	niy one cause on	PACH INE.	1 An	1004		ease				Interval Between Opset and Death
	/Medical		disease or condition resulting in death)	a. Due to	o (or as a consec	gence of):	109	V 1)(MIC				rens
Ε	xaminer					, , .							
1-		Der	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a conseq	juence of):							
1/3	nd	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с									
/ 00', be eve	ien a urial-i	Ä	resulting in death) Last	Due to	o (or as a conseq	luence of):							
Oo / OU,	been signed by the attending physicien and should be deteched for use as the burial-transit	dical	9	d									
	o as		IF FEMALE:										
אַ מ	ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live	outcome of pregna birth 2 Peta	ıl death 3 □	Ectopic pregr				2	3d. Date of del Month	ivery Day Year
. 9	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pre-	gnant at time of d known	leath 5∟	Other (specif	y)					,
The law requires that the death cedif	ad by detec		Part II. Other significant condition	s contributing to	death but not res	sulting in the u	nderlying caus	e given in Part	1.	23e, Did to	obacco us	se contribute to	the cause of death?
ָרָ בְּיֵלְי	Sign Ba	þ	,			3	,	- g	•		/es 2□		`
5	peen	Completed								-			
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	r, pag									1□ Yes	21/2 No	1 ☐ Yes	2□ No
V Sich	certif	Be	25. Was case referred to medical examiner?	Hospital:		15510		Other		(Check only o			
5 6	rthis naldi	5 5	1 Yes 2/7 No 27. Manner of Death	1		ER/Outpatien		4 🗆 N		8d. Describe h		Other (Spec	cify)
5 5	h. Afte fune	to For	1 atural 5 Pending 2 Accident investig		e of Injury onth, Day Year)	Injury	м	Injury at Work?			,		
VISION	r dea	fica	3 Suicide 6 Could no	ot be 28e. Pla	ce of Injury - At h	ome, farm, str	eet, factory, of	fice	2				ıral Route Number,
DIVISION OF VICE	within 24 hours after death. To the Funerel Director; After this centificate has completely filled in by the funeral director, page 2.	Certification:	4 Homicide	buil	lding, etc. <i>(Specil</i>	(y)				City or Tov	vn, State)		
100	hour ty fill		29a. Certifier Certifying	Physician: To to xaminer: On the	he best of my kno	owledge, death	occurred at t	ne time, date a	ind place, a	nd due to the	cause(s)	and manner as	stated.
1	in 24 the F iplete	ledical	one)	and ma	inner stated.				alli occurre				
5	To Loo	Σ	29b. Signature and title of certifier	5 1	-	ALK	29c. Li	cense number	74		29d. Date	signed (Monti	n, Day, Year)
			r monuel	4/1		10.1	V	717	17		HU	9 UST	112006
	6		30. Name and address of person w		use of death (Ner	n 23a) (Type,	Print)	4+10 P	atin	1 tugy	k.	Col	am jajanu
	-	10	31. Date filed (Mogth, Day, Year)	(11	Registrar's Signa	ature A	10 1 0	11101	VUIV	revi 1	- Wy		71014
	Sta		AUG 0 3	2006 7	N.C. en	A An	21/1						•

Please Type or Print in Black Indelible Ink

Daniel S. Debois		State of Maryla - For State Registrar		ment of l ficate of i		i wentai H		eg. No. 2 []	116 21.36
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle,Last) DANIEL	STEVEN	1	DeBOIS		Date of Deat Month	th Day Year	3. Time of Death 1942 hrs
vieulcai Examin		4a. Facility Name (if not institution, give street and nu			. City, Town, or L	ocation of Death	July 30, 2	4c. County of De	
		University Hospital			Baltimore	Two and	lo por co		N/A
Funeral Director		5. Social Security Number 6. Sex 1 X M 2 F	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min.	-		Birthplace (State or ireign Country) MD
	ŀ	Usual Residence of Decedent			1		1 07/03	7 1302	
ow any		MD HOWARD	10c. City, To	own or Locatio	ott CIT	V			10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f sliow d at once.	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What 0	Λ
ith the Maryland 23a or 28a-f slio notified at once.	١	10182 HOBSONS CHOICE				21042			USA
hours after death with the Maryland 'natural', or items 23a or 28a-f slo Examiner must be notified at once	Funeral	1 X Never Married 2 Married Armed F			Decedent of Hisp , specify Cuban,			- 14. Race - Ar White, etc	merican Indian, Black, c.
after de	by Fr	3 Widowed 4 Divorced If Yes, Give Yes or Dates:			es 2X No			Specify:	WHITE
hours "natur	ted t	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12) College (1)			Usual Occupation Usual Occupation Usual Occupation			16b Kind of Busine	ss/Industry
15-0036 filed within 72 hours after 1 Hygiene d other than "natural", t, the Medical Examiner	Completed	12	,	ARTIS	ST			ART	
21215-0036 uld be filed within 7 Mental Hygiene marked other thau	Be လ	17. Father's Name (First, Middle, Last) RICHARD		DeB01		8 Mother's Name CHERYL		Maiden Surname)	DAMRON
D 2121 should be fi and Mental 7 is marked		19a. Informant's Name/Relationship (Type, Print)	ED.			and Number or F	Rural Route Nun	nber, City or Town, Si	tate, Zip Code)
E C C E	-	RICHARD DeBOIS / FATH 20a. Method of Disposition			on (Name of cem		Date -	ELLICOTI 20c. Location - City	CITY, MD21042
Baltimore, permit Pages I an Department of Hee Important: If itee		1 Burial 2 X Cremation 3 Removal fr 4 Donation 5 Other Specify:	om State HIL	matory or othe LTOP SE	rplace) RVICE CO	ORP. 08/	03/2006	TOWSON	, MD
Baltimo permit Page Department of Important: injury or ott	Ì	21. Signature of Funeral Service Licensee			me and Address	-	SOL LEV	INSON & B	ROS., INC.
Physician	-	23a. Part/l. Enter the disease or complications that of	aused the death. D	o not enter the	900 REIS	STERSTON such as cardiac o	IN ROAD r respiratory arm	- PIKESVI	LLE, MD 21208
/// ed cal		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Inj							Between Onset and Death
, Adminier		h	consequence of):						
	<u>i</u>	cause Enter Underlying Cause	consequence of):						
lit d	Examine	(C) Sease or initial that initiated C.	consequence of):						
executed an and all - transit		ddAMENDED							
760, cate be exemply sician the burial -		IF FEMALE. 23c. If yes,	outcome of pregna	ncy				23d. Date of deli	very
Box 6871 e death certifica the attending pl ed for use as th	cian/	23b. Was decedent pregnant in the past 12 months?	oirth nant at time of deatl		Ideath 3 er (Specify)	Ectopic pregna	nncy	Month	Day Year
BO) ne death r the att	Physician/	1 Yes 2 No 9 Unknown 9 Unkn					OO- Didd	1	1
Division of Vital Records, P.O. sa or Attending Physician: The law requires that the safter death all Divertor: After this certificate has been signed by led in by the funeral director, page 2 should be detact	ক্র	Part II. Other significant conditions contributing to	o death but not resi	uiting in the un	deriying cause gi	ven in Part I.	parties and the same of the sa		e to the cause of death? Probably 4 Unknown
Sords, Plaw requires that been sign 2 should be expensed	Completed						24a. Was autop		e autopsy findings available to completion of cause of
Recc The lav	ĕ							rmed? death	n? Yes 2 No
Vital Rec ssician: The l his certificate be director, page	Be	25. Was case referred to medical examiner? Hospital: 4	Inpatient 2 🗸 E	P/Outpatient	I/	of Death (Check	only one)	Residence 6 0	ther:
of Vi	٦. ا	27. Manner of Death 28a. Date	of Injury 2	8b. Time of In	lana and	y at Work?	28d. Describe	how injury occurred	
Vision of Vor Attending Phorector: After the hinby the funeral	atio	2 Accident Investigation		1910 hrs		es 2 🗸 No		ped from a heig	
Divis	Certification:	Suicide Could not be	e of Injury - At hom Interstate/Ex		, factory, office bu	uilding, etc.	or Town, S	State)	Rural Route Number, City Windsor Mill, MD
		29a. Certifier 1 Certifying Physician: To the be	st of my knowledge	, death occurre			due to the caus	e(s) and manner as	started.
To the Ros within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis and manner: 29b. Signature and title of certifier		/or investigation	29c. License		at the time, date	and place, and due to 29d. Date signed (
		Mlan Brascoll	UA		O.C.N	И.E.		July 31, 2006	,,
10	ŀ	30. Name and address of person who completed cau			nn Street C	altimore \$45	21201	1	
62-01-12	ate		edical Examine		enn Street, Ba	animore, MD	21201	·	
Regist		AUC 0 3 2008 A	Magica o de	y fine	whi				

			1 - For State Registrar	State of Marylan		artment of I tificate of			giene Reg. No 2006	24362
	Physic		Decedent's Name (First, Middle, Last)	Dorothy Ell	iott			2. Date of De. Month	ath Day Year 2004	3. Time of Death
*	/Medi Examir - Funeral		4a. Facility Name (If not institution, give s	lare Hos	• • • • • • • • • • • • • • • • • • • •	4b. City, Town, of Rose If Under 1 Year Months Days	or Location of Dec	s. 8. Date of Bird	4c. County of Death	MG (Paplace (State or Foreign untry)
The Confession of the Confessi	Director		212-92-8187 Usual Residence of Decedent 10a. State 10b. County	M 2♥F 87	Yrs.		110010	Dec. 18		nsylvania 10d. Inside City Limits
	he Maryli 8a-f sho	ector	Maryland Balt	cimore			Col	gate		1 ☐ Yes 2 X No
ゝ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show shy Injury or other traumatic event, the Medical Examinar must be notified at once.	Funeral Director		Was Decedent Ever in U. Armed Forces?	.S. 13. V	10f. Zip Code Vas Decedent of F Yes, specify Cub	212 Hispanic Origin? an, Mexican, Pue	24 (Specify Yes or No	10g. Citizen of What Cou United Sta 14. Race - Amer Black, White	ates ican Indian,
5-0036	72 hours after natural', or Ite		1 Never Married 2 Married 32 Widowed 4 Divorced 15. Decedent's Educ	1 ☐ Yes 2 X No If Yes, Give Year or Dates: ation	16a. Deced	l ☐ Yes ŽŽŠNo lent's Usual Occup	pation		Specify: V	White ndustry
2121	led within 7 ygiene. ner than "n	Completed by	(Specify only highest grade Elementary/Secondary (0·12) 8 Years	College (1-4or 5+)	life. L	kind of work done DO NOT use retire memaker	d)		Own Ho	me
yaidd y	should be filling Mental H marked ott umatic even	To Be	17. Father's Name (First, Middle, Last) Jeremiah Hossler				Al	ice Eise		
, Mary	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship (Type Debbie Engram	(Guardian)	82	5 Easter			er, City or Town, State, Zi re, Maryland	/
Baltimore,	Pages 1 nent of Hi ant: If Iter ury or oth		20a. Method of Disposition ★★Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	emetery, cren	sition (Name of natory or other pla Mem. Pk	·	Date 4/2006	20c. Location - City or T	own, State Maryland
Balt	permit. Departrimports eny inju		21. Signature of uneral Service License	Rel	22	Name and Addre Duda-Ruci 7922 Wise	ss of Facility K Funera Ave.	l Home of Dundalk,	f Dundalk, I Maryland 2	Inc.
	Physician /Medical Examiner		23a. Part1. Enter the disease or complic shock, or head arture. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the death e cause on each line. Due to (or as a consequence)	psi-	er the mode of dyin	ng, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death Conset and Death
8760,	ate be executed thysician and the burial-transit	dicai Examiner	Sequentially list conditions, but any Leading to time scillate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)						
O. Box 6	Physician: The law requires that the death certific: this certificate has been signed by the attending pl ral director, page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\triangle \text{ yes} \) 2 \(\triangle \text{ No} \) 9 \(\triangle \text{ Unknown} \)	ic. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of do 9 Unknown	Ideath 3 🗆	Ectopic pregnancy Other (specify)	1		23d. Date of deliv Month	rery Day Year
ords, P.	w requires that been signed I should be det	þ	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the ur \mathcal{D} (derlying cause giv	ren in Part I.	23e. Did to	obacco use contribute to r res 2 ⊠No 3 □ Pro	the cause of death? bably 4 □Unknown
of Vital Records,	: The law recate has be page 2 shu	Completed	Respira	tory f	erilu	7		24a. Was autop perfor	sy prior to co	oppsy findings available ompletion of cause of 2 No
f Vita	Physician: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 20 No	ospital: 1 Inpatient 2	ER/Outpatient	: 3□ DOA Oth	or	eath <i>Check only</i> of	nel	fy)
o uoi	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		27. Manny of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1 🗆	y at k? Yes 2 □ No	28d. Describe h	ow injury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Number or Runn, State)	al Route Number,
	To the Hospital or A within 24 hours after within 24 hours after completely filled in by	Medical	29a. Certifier Check only one) Certifying Physical Certifying Chysical Exemination (Check only one)	cian: To the best of my kno er: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the tir estigation, in my o	ne, date and place pinion, death occ	ce, and due to the courred at the time, of	cause(s) and manner as s date and place, and due t	itated. o the cause(s)
	To the To the County	×	29b. Signature and title of certifier	p. p.o.		29c. Licens	e number 3 5 5 9 1		29d. Date signed (Month,	Day, Year)
	(0)		30. Name and address of person 100 m	npleted cause of death (Item	23a) (Type, I	Print)		a (fin	Ne M	0 2021
	Sta Registr		31. Date filed (Month, Day, Year) ALIG 0 3 20	32. Redistrar's Signa	ture	beste		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-1.	1. 4/4(1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | | 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** George Nicholas Fach, Jr Aug. 2006 8:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1428 Washington Ave. Severn Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1**X**M 2□F Months Hours 53 142-48-4355 Yrs. Director Nov. 6, 1952 Ohio Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow other traumatic avent, the Medical Examinar must be notified at 1 ☐ Yes 2 👿 No Directo Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1428 Washington Ave. or Items 23a 21144 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) US Army Corp of Elementary/Secondary (0-12) College (1-4or 5+) Engineers Civil Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Nicholas Fach, Sr Sylvia Anne Fellows 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Ia m any Injury or other traum once. Elizabeth Anne Fach/wife 1428 Washington Ave. Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State West Arundel Crematory August 3, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Odenton, MD 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Rd., Odenton, MD 21113 21. Signature of Funeral Service Licensee Somerico 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between melanoma Onset and Death Immediate Cause (Final **Physician** o years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown þ been signed be should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No certificete 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a

P.O. Box 68760,

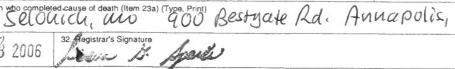
Division of Vital Records,

31. Date filed (Month, Day, Year)
AUG 0 3 AUG 0

29b. Signature and title of certifier

tuaut

29a. Certifier



State

Registrar

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

19838

29d. Date signed (Month, Day, Year)

			1- For Amend item#2, perMD, 8558, 8/3/06 11 Certificate of Death Reg. No. 24/3	64
			1. Decedent's Name (First, Middle, Last) 2. Date of Death July 7, 2006 3. Time of De	eath
	Physici /Medic		Month Day rear	PM
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
			St. Thomas MOORE HYATTSVILE PRINCE GEOLY	1-6
	Funeral		5. Social Security Number 6. Sex 12M 2 F 7. Age (In yrs. last birthday) 11 Yrs. 12 M 2 F 7. Age (In yrs. last birthday) 15 Under 1 Year If Under 24 Hrs. 16 Under 24 Hrs. 17 Months Days Hours Min. 18 Days	oreign
	Director		Usual Residence of Decedent)C
	Maryland -1 show		10a. State 10b. County 10c. City, Town or Location 10d. Inside City	Limits
	B-1 st	tor	MD PRINCE GEORGE F.t. WASHINGTON 1000 2	. 🗌 No
	with tha e or 28s)ire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	ifter death with tha Marylar r Items 23e or 28a-f show iner must be rollified at	Funeral Director	7706 Klovstad Drive 20744 United STATES	
	er de	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
36	0 0	by F	1 Prover Married 2 Married 1 Yes 2 Provided 2 Yes 2 Provided 1 Yes 2 Provided 2 Yes 2	
5-0036	72 hours 'natural' Jical Ex			
215	C 34	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	
2121	filad wil Hygien thar th	Соп	unknown Auto MECHANIC Auto Repair	
Ind	0 @	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
y la	should be nd Menta marked imatic av	2		
Maryland	20.00			111
_	is 1 and of Health itam 27 other to		JEAN FOWLER (MOTHER) 7706 KLOVS STODE Ft. WITS IT NO. TON 2075 20a. Method of Disposition (Name of Date 20c. Location - City or Town, State	14
JOI.	65 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	X.
Baltimore,	permit. Page Department Important: I eny injury o	ì	"4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROB RT G. MASON FI	
B	Depa Impo eny ii		Mala Gan HOE ON GA WASH NG 200	20
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dea	on
-	Physician		Immediate Cause (Final disease or condition resulting in death) a. Human Immuno deficiency Vin-SIAIDS year	ath
A	/Medical		resulting in death) Due to (or as a consequence of):	<u> </u>
	Examiner		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	lad nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	
	ba axacutad ician and burial-transit	xar	that initiated events c	
760	ite ba a: iysician he buria	cal	d.	
\ 89				
Вох	eath certifica attanding pl	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	
	T 0 T	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Yea	τι
P.0	a >	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death	•62
ds,	Se un es	Completed by	Throm 50 cy to penial 1 yes 2 No 3 probably 4 Unk	
Ö		etec	A	
Rec	e la has	m	24a. Was an autopsy findings ava prior to completion of caus death?	se of
a	icien: Th certificate rector, pag	e Co	25. Was case referred to medical 26. Place of Doorth. Charle and are	
>		To B	25. Was case referred to medical examiner? 1	121
10	ding Phys h. After this funeral di		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
ioi	Attanding r death. actor: After by the funer	atlo	2 Accident investigation M 1 Yes 2 No	
Division of Vital Records,	or Attanter deat iractor:	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Could not be determined 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 5 ☐ Could not be determined 6 ☐ Could not be determined 6 ☐ Could not be determined 6 ☐ Could not be determined 6 ☐ Could not be determined 7 ☐ Street and Number or Rural Route Number 8 ☐ City or Town, State)	r,
	To the Hospital or Attant within 24 hours after deati To the Funeral Director: completely filled in by the	Ce	200 Continue 1 Continue Physician To the heat of my	
	Hos 24 hc Fun stely f	edical	29a. Certifier (Check only one) Chack only one) Check only one) Check only one) (Check only one) Check only one) Check only one) Check only one) Check only one Check only one Check only one Check only one Check only one Check only one Check only one One Check only one Check only one One Check only one One One Check only one One One One One One One One	
	To the	Med	29b. Signature and jitle of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
	->-0		Mullen Wolling D01852 9504 20016	
			30. Name and address of person who completed cause of death (Item 23a) (Type Print)	~ ~
_			PAUL A. DEVORE, MD 4203 QUEENS BURY Ed HYGTBUILLE, MD ZO	151
R	Sta Registr		29b. Signature and vittle of certifler 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 31. Date filed (Month, Day, Year) AUG 0 3 2006 32. Reference of Month, Day, Year) 33. Reference of Month, Day, Year) 34. Date filed (Month, Day, Year) 35. Reference of Month, Day, Year)	

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Albert Thornton		1- For State	State	of Maryla	nd / [tment of	f Health ar f Death	nd Mer	ntal Hyg		Dan Na	20	06	2436
Physicia		Registrar 1. Decedent's Name (First,	Middle,Las	st)						2	. Date of De			3	Time of Death
Medical Exami	ner	ALBERT THOR									Month July 31,		Year		1415 hrs
		4a. Facility Name (if not ins		e street and nu	mber)			4b. City, Town, o Baltimore	r Location	of Death					
		5. Social Security Number	6. S	ex	7 Age (I	In vrs. las	t birthday)	If Under 1 Ye	ar I If Und	ler 24Hrs.	8 Date of F		BALTIM		CITY place (State or
Funeral Director				√M 2 F	, , , , go (.		Yrs	Months Da		s Min.			F	oreign	
	ŀ	212-58-7223 Usual Residence of Deced		JIVI ZF		55	115	1			NOV.	4, 1	950 <u>I</u>	-	tryMARYLAND
au)		10a. State 10b. Co			10	c, City, T	own or Locat	ion	-						0d. Inside City Limits
and Fshow	ь	MARYLAND DO	RCHES'	TER		HUR	LOCK								1 Yes 2 X No
Mary 1. 28a-	Director	10e. Street and Number						10f. Zip Code				10g Citi	zen of What	Country	y?
ith the Mary land 23a or 28a-f show notified at ones.	- 1	305 COLLINS	AVE.	T			T to the	21647					ITED S		
cath wi items ust be	neral	11. Marital Status 1 Never Married 2	Married		orces?			is Decedent of H es, specify Cuba				10-	14. Race - A White, e		n Indian, Black,
cr de	Fun	3 Widowed 4	Divorced	1 Yes If Yes, Give Yea	2 X	No	1	Yes 2X N	o specify	r:			Specify: 1	WHIT	rE
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she af Examiner must be notified at once	d by	15. Decedent's Education	- No.	or Dates:		eted) 1		nt's Usual Docupa	ation (Give	kind of wo		16b.	Kind of Busin		
6 72 h cal Es	lete	Elementary/Secondary (0-12)	College (1	-4 or 5+)		auring m	ost of working lif	e. DO NO	i use retire	a)				
003 within jene ner tha	Completed	47.5-11.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.		2			PRODU	CTION WO			First, Middle			MA	NUFACTING
21215-0036 uld be filed widin 7 Mental Hygiene marked other thau	Be	17. Father's Name (First, M											Surname)		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Memal Hygier and intention of the part is marked other than "natural", or other transmatic event, the Medical Examiner.	To B	ALBERT T. FO	ationship (y DK. Type, Print)			19b. Mailin	g Address (Stre	et and Nu	M M. mber or Ru	STANK I	umber, C	ity or Town,	State, Z	(ip Code)
MD of 2 sho ofth and n 27 is		SABRINA BEAL	4 / D	AUGHTER			222 P	HILLIP N	10RRI	S DRI	VE,	SALI	SBURY,	_MD	21804
re, land freal		20a. Method of Disposition 1 Burial 2 X Cre		Removal fr	om State	1	ace of Dispos ematory or ot	ition (Name of co her place)	emetery,		Date	20c.	Location - C	ity or To	own, State
Page nent o ant: I or oth		4 Donation 5 Qt	ner Specify	<i>/</i> :	om otate	1	RO CRE	MATORY		AUG.	5,200	6 CA	TONSVI	LLE	• MD
Baltimore, pounit Pages Lat Department of Hee Important: If ite injury or other it		21. Signature of Funeral S	ervice Lice	nspe			22. N K T	Name and Addre	ss of Facili	ty K FIIN	ERAL 1	HOME	. Р.А.		
	1	23a. Part I. Enter the disea	A Or com	plications that c	aused the	a death F	142	I CRAIN	HWY.	S.E.	GLEI	N BU.	KNIE,	MD .	21061 Approximate Interval
Physician /Med cal		failure. List only one	cause on e	ach line.					g, 00011 00 ·	our dido or i	oopii atory a	11000, 0110	oon, or nour		Between Onset and Death
Examiner	19	Immediate Cause (Final di or condition resulting in de		Due to (or as a			coxicity							-	
		Sequentially list conditions	b, b												
	Examiner	if any, leading to immediat cause. Enter Underlying (е	Due to (or as a	consequ	uence of):									
=	хаш	(Disease or injury that initi events resulting in death)		Due to (or as a	consequ	uence of):								_	
be executed sician and urial - transit			d											\rightarrow	
0, the execut sician and	edical	X UNPENDED		AMENDED	item	#23a.2	27 , 28a-f	perME.g8	58,8/2	28/06 T	T				
Box 6876C he death certificate the attending physhed for use as the b	n/M	IF FEMALE: 23b. Was decedent pregna	nt in the	23c. If yes,		of pregna		etal death 3	Ectop	ic pregnan	CV	23	d. Date of de Month	elivery Day	y Year
x 61 th cort tendir r use a	sician/M	past 12 months?	7	4 Pregr		ne of dea		ther (Specify)		, ,	,				,
Box ne death curthe attented for us	Phys	1 Yes 2 No 9	Unknow	9 Olikii							00- Did) - l		1 - 1 - 4b	
, P.O.	by F	Part II. Other significant	conditions	contributing to	o death b	ut not res	suiting in the i	underlying cause	given in P	aπ I.					e cause of death?
Cords, P.O. Box 6876 law requires that the death cutificate has been signed by the attending phy 2 should be detached for use as the b							_				24a. Wa				psy findings available
COTC faw re has be	Completed											opsy formed?		or to con ath?	npletion of cause of
Ital Recor	ပ်	OF 10/2	e direct					26 Dine	as of Death	· (Chook or	1 Yes	2 N	lo 1 🗸	Yes	2 No
Ttal sician is certi	Be	25. Was case referred to r examiner?	Ì	Hospital:	Inpatient	2 F	ER/Outpatient		Other ₄	Nursina	Home 5	Reside	ence 6 🗸	Other: 5	Scene
of Vital Records, og Physician: The law require. The this certificate has been si meral director, page 2 should b	: To	1 ✓ Yes 2 N 27. Manner of Death	0	28a. Date	of Injury		28b. Time of		jury at Wor		-		ury occurred		
On cendin ath	ıtion	1 Natural 5	Pending	End	7/31/		Fnd 2:0	00 pm 1	Yes 2	No i	ngestio	on of	ethyler	ne gl	lycol
Division tal or Attendir as after death al Director: A	Certification:	2 Accident 3 X Suicide 6	Investigated Could not	28e Plac	e of Injur	y - At hor	me, farm, stre	et, factory, office	building, e	etc. 2	8f. Location	(Street a	and Number	or Rura	Route Number, City
Di pital ours a filled	Cert	4 Homicide	determine	ed (Specify)	fou	nd in	parking	g garage		J.	Baltim	ore, I	11 Fast MD		
Division of Vital Rec To the Hospital or Attending Physician: The within 44 hours after death To the Funeral Director. After this certificate completely filled in by the funeral director, page								rred at the time, ition, in my opinio							
To the comp	Medical	29b. Signature and title of		and manner	stated				nse numbe		a 10 timo, aa		Date signed		
1111	٦	(a L s l	2 11	A 00	1.			:	.M.E.			Ι.	gust 1, 20		., 2aj, rouij
200		30. Name and address of	person who	completed cau	se of dea	ath (Item	23a)								
a ly		Carol Allan, MD		ant Medical				Street, Baltir	nore, MI	D 21201					
\$	tate	31. Date filed (Month, Day	Year)	32. R	eoistrar's	Signatur				-					
Regis	trar		09 2	nne I	20		K A	acts 1							

ORIGINAL

	,	Please 1 1 - State Registrar		ryland / Depa	delible Ink. Ensurantment of Health a difficate of Death	-		gible. 006 24361
Physicia /Medic		Decedent's Name (First, Middle, Last) ANNETTE	: S	5. F	ISHKIND	2. Date of D Month Augus	Day	Year 2006 ILITT A M
Examin Funeral Director		4a. Facility Name (If not institution, give some facility Name (If not institution, give some facility Number	Battine	o (In yrs. last birthday) 83 Yrs.	4b. City, Town, or Location of Bakinore If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of B		N/A 9. Birthplace (State or Foreig
filed within 72 hours after death with the Maryland Hygiene. sther then "naturel", or items 23a or 28a-1 show ent, the Medical Examinar must be notified at	Director	10a. State 10b. County MD BALTIMO 10e. Street and Number 7203 ROCKLAND HIL		10c. City, Town or Lo BALTI			10g. Citizen o	10d. Inside City Limit: 1 □ Yes 2 ☑ No of What Country? USA
s 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene. I Health and Mental Hygiene. I Health are 23e or 28e-f show ther traumatic event, the Medical Examinar must be notified at	d by Funeral		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 Ø N If Yes, Give Year or Dates:	Ever in U.S. 13. V	Was Decedent of Hispanic Orig f Yes, specify Cuban, Mexican, I ☐ Yes 2 ☒ No Specify:	in? (Specify Yes or N Puerto Rican, etc.)	14 R B Spec	ace - American Indian, lack, White, etc.
ad within 72 h /giene. ier then "natu	Completed	15. Decedent's Edu (Specify only highest grad.		(Give	dent's Usual Occupation kind of work done during most DO NOT use retired)	of working	16b. Kind of UPHOL	Business/Industry
should be file and Menta! Hy s marked oth: umatic event	To Be (17. Father's Name (First, Middle, Last) MEYER 19a. Informant's Name/Relationship (Ty			IAN LENA	or Rural Route Num	ber, City or Tow	FRUMAN m, State, Zip Code)
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then any injury or other traumatic event, Ite Manage.		PHILIP M. FISHKIN 20a. Method of Disposition 1 \(\frac{1}{A} \) Burial 2 \(\) Cremation 3 \(\) F 4 \(\) Donation 5 \(\) Other (Specify)		20b. Place of Dispo- cemetery, cren	ROCKLAND HILL sition (Name of natory or other place) PARI ZION OF LIBERTY	Date	20c. Location	TIMORE, MD 2120 n - City or Town, State LLSTOWN, MD
permit. F Departm Importer any injur		21. Signature of Puneral Service Licens 23a. Part 1. Enter the disease, or compl	attle	22	Name and Address of Facility	SOL LEVI DWN ROAD -	NSON & PIKESV	BROS., INC. ILLE, MD 21208
Pnysician /Medical Examiner		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each lin	е.	or the mode or dying, such as t	ardiac of respiratory	arrest,	interval Between Onset and Death 3 Weeks
o	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):				
that the death certificate bed by the attending physic detached for use as the b	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 1 4 Pregnant at 9 Unknown	2 ☐ Fetal déath 3 ☐	Ectopic pregnancy Other (specify)			Date of delivery Month Day Year
w re, uires that been signed b should be deta	by P	Part II. Other significant conditions con HIS ory of Bee	stributing to death bu		nderlying cause given in Part I.		tobacco use co Yes 2,200	ontribute to the cause of death?
in: The law r ificate has be or, page ash	e Completed	Hypo thyro ident				per 1 ☐ Yes	opsy formed? 2 No	b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
ing Physicia After this cert uneral direct	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Autural 5 Pending	ospital: 1 Inpatien 28a. Date of Injur (Month, Day	y 28b. Time of	t 3 DOA Other: 4 Nur 28c. Injury at Work?			
To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, stre (Specify)	M 1 ☐ Yes 2 ☐ Neet, factory, office	28f. Location	(Street and Num own, State)	mber or Rural Route Number,
the Hospi thin 24 hour the Funer mpletely fills	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 2 Medical Examination (Check only one)	sician: To the best of ner: On the basis of and manner sta	examination and/or inv	n occurred at the time, date and yestigation, in my opinion, death	place, and due to the occurred at the time	, date and place	manner as stated. a, and due to the cause(s) med (Month, Day, Year)
i		30. Name and address of person who co		eath (Item 23a) (Type	RES OC	0		1,2006
V Sta	te ar	Remilekun S Do 31. Date filed (Month, Day, Year)				112,2401 W	Betrechere	e Are, Ballimore MD

State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY 29 Day 2006 Year **Physician** FRIFDMAN 8:20 P M SARA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE NORTHWEST HOSPITAL CENTER RANDALLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1271971918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💯 F MD 212-01-1751 87 Director Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 No BALTIMORE Directo BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Iteme 23a or 21208 7 SUDBROOK LANE USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
The filem 27 is marked other then "naturel; or its marked other then "naturel; or its ury or other treatmatic event, the Madical Engine 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify: þ Specify: 3 X Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry CO. Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** RESNICK-HOLLINS POULTRY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be BAYLIN LENA NOVAK JULIUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 SADDLE COURT - BALTIMORE, MD 21208 JANICE DANSICKER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) CIRCLE Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of important: If eny injury or once. BOBROISKER BENEFICIAL 08/02/2006 ROSEDALE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 SUC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTICEMIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner UROSEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Dther (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be 3 Probably 4 Unknown 1 ☐ Yes 2 ☑ No Completed been 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 X No certificate 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 Inpatient 2 2 ER/Outpatient 3 DOA completely filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation death. М 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifiei 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 29c. License number JULY 29, 2006 D43977 idness of person who completed cause of death (Item 23a) (Type, Print) OFFICE TUNT 301 HUSI 1... 301 HOSPITAL DRIVE - GLEN BURNIE, MD 21061 MYOKEN 31. Date filed (Month, Day, Year) State 3 2006 0

DHMH 17 Rev 1/2001

Registrar

AUG

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year JULY Nick G. Greene 20 6:20pm 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LA PLATA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F Yrs. Director Dec 27, 1917 88 New York 221-16-5677 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f ehow or other traumatic event, the Modical Examinar must be motified at 1 Yes 2 No Directo MD Charles LaP1ata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Magnolia Drive 20646 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. unk 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed with and Mental Hygiene. unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked eny Injury or other traumatic evange. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Civista Medical Center 701 E. Charles Street LaPlata, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑Donation 5 ☐ Other (Specify) 21. Signatur of Funeral S, rvice Licensee Ronald S. Wa 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 egtor ann, 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ-Examine physicien and s the burial-transit Records, P.O. Box 68760. a attending phyw. ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 Other (specify) Physi 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 1 NO To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 No 1 npatient 1 Tyes 2 ER/Outpatient 3 DOA this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) Mus D-57708 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABBAS A. OMAIS MD 7c POST OFFICE ROAD WALDORF MARYLAND 20602 32 Registrar's Signature 31. Date filed (Month, Day, Year) AUG 0 3 2006 Section of Registrar

			1 - For State Registrar	State of Maryland	•	artment of H tificate of L		Re	g. No.	16	24369
	Physici		Decedent's Name (First, Middle, Last, Teresa Haged					July 31,		Yeer	3. Time of Death 1:25a M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Locetion of Deal		4c. County	of Death	
			Hillhaven Nursing	Center		Ade1ph:	i		Prince	Geor	ge
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. las	**	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	Year)		ece (State or Foreign try)
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	/land		10a. State 10b. County	10c. City,	Town or Lo	cation				11	Od. Inside City Limits
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980	d within 72 hours after death with the Maryland Jene. r than "natural", or Items 23a or 28a-f show the Medical Exaction must be multified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	ĺ	Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2 1 No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		- Americ c, White, c Whi	
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Baltimore,	permit. Pages 'Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licens					ational F ls Church		Home 2204	2
I			23a. Pert1. Enter the disease, or compl shock, or heart failure. List only or	ications that ceused the deeth. ne cause en each line.	Do not ente	er the mode of dying	, such as cardia	c or respiratory arre	st,		Approximate Interval Between Onset and Death
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	ocuted nd transi	Examiner	that initiated events	3							
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Box (death certificate be executed e attending physician and of or use as the burial-transi	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnanc					23d. Date	of delive	y
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Division of Vital Records,	I or Attending after death. Director: Afte I in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, fectory, office		28f. Location (Str. City or Town,	eet and Number State)	r or Rural	Route Number,
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	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physical Examination	sician: To the best of my knowle ner: On the basis of examination and manner stated.	n and/or inv	estigation, in my op	inion, death occu	irred at the time, da	e and place, ar	ner as sta nd due to	the cause(s)
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	ι Sta	te	31. Date filed (Month, Day, Year)	SEAY 10801 2. Registrar's Signatur	0	K WOOD I	VR. JI	2000 Sp.	King "	10	10701
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06-05653 Marvin Harris

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II VII t			State of Maryland / Department of F 1-For State			eg No. 200	6 2437
dica	Physici I Exami	an/	Decedent's Name (First, Middle, Last) MARVIN HARRIS		2. Date of Deat Month August 1,	h	3. Time of Death 1805 hrs
				City, Town, or Location of E Baltimore		4c. County of Death	
	Funeral Director			If Under 1 Year If Under 2 Months Days Hours		th(MM/DD/YYYY) 9. Birt	hplace (State or north ARYLAND
	d how any	_	Usual Residence of Decedent 10a. State	RE CITY			10d. Inside City Limits 1X Yes 2 No
	ish the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 3310 INGLESIDE AVENUE	0f. Zip Code 21215	10	Dg. Citizen of What Cour	try?
	filed within 72 froms effer death with the Maryland. Hygiene	y Funeral	1 Never Married 2 Married Armed Forces? 1 X Yes 2 No 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes	ecedent of Hispanic Origin' specify Cuban, Mexican, Pi es 2 No specify:		White, etc.	BLACK
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<i>n</i>	7		1 If me and address of person who completed cause of death (Item 23a)				
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State of Maryland / Department of Health and Mental Hygiene [] [] [For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 11, **Physician** Annette Hall 2006 7:35 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 834 W. Saratoga Street Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) **Funeral** Days Hours 1□M 2♥F 57 Director 215-52-4297 Dec 28, 1948 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f show the Medical Examiner must be notified at 1√ Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 834 W. Saratoga Street 21201 Pages 1 and 2 should be filed within 72 hours after death USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 XNever Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "naturel", or 1 ☐ Yes 2 No ģ Specify: black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) Cotlege (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglient Important: If item 27 is marked other that any injury or other traumatic event, the QRCB. 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Be Annie Sembly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kendra Davis/daughter 45 Ojib Way Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State *4 □ Donation 5 ☑ Other (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 muss. Baltimore, MD Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, teading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physiclan/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) the 9□ Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy nohed certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 5 Residence 6 □Other (Specify) 3□ DOA funeral 27. Manner of Death Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Sescribe how injury occurred After 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No Director: A 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title who completed cause of death (Item 23a) (Type Print) 30, Name and address of person Hanc Baltimore, ١٢,

State

Registrar

31. Date filed (Month, Day, Year)

0

3 2006

32 Registrar's Signature

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	or waryland / De		ate of De		Wentarri		g. No 2	00	6 2637
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last)						Date of Death Month	Day Yea		3. Time of Death
iviedicai Exami	ner	Mattie Hicks 4a. Facility Name (If not institution, give			4b 0	ity Town or Lo	ocation of Death	Month July 31, 20	4c. County of	of Death	1045 hrs
		2503 Violet Avenue #712				altimore			N/A	. Dodin	
Funeral		5. Social Security Number 6 Sex	7. Age (In	yrs. last birth	· · ·	Under 1 Year	If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY	9. Birth	place (State or
Director		129-18-3860	м 2ХГ 8	3	Yrs N	lonths Days	Hours Min.	11/24/	1922	Foreign Coun	www.York
any		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town	or Location						Od. Inside City Limits
\$		MD N/A		Balt:						- 1	1 X Yes 2 No
faryland 28a-f show 1 at once.	Director	10e. Street and Number		рат с.		f. Zip Code		10	g. Citizen of Wh	nat Countr	y?
n the N 3a or 2	- 1	2503 Violet Ave	nue - #71	.2		21225	5		U.S.A.	•	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	uneral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever Armed Forces?				anic Origin? (Sp Mexican, Puerto		14. Race White		in Indian, Black,
ter dea	뜨		1 Yes $2X$	No .	1 Yes	2 X No	specify:		Specify:	D1	o olt
eurs afi itural	d by	15. Decedent's Education (Specify onl	or Dates:	ed) 16a. [ecedent's U	sual Occupation	n (Give kind of w		16b. Kind of Bu		ack Justry
6 72 ho m "na cal Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	(luring most a	of working life D	OO NOT use retir	red)			
5-0036 fled within 77 Hygiene I other than the Medical	duc	12 17. Father's Name (First, Middle, Last)		Sea	amstr		NA-Maria Nama				usiness
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ID 2121 should be f and Mental 7 is marked	TO B	19a. Informant's Name/Relationship (Ty	pe, Print)	19b	. Mailing Add			Rural Route Numl		n, State, Z	(ip Code)
, MD and 2 show leafth and 1 stem 27 is traumatic		Ladoris Lewis		70	03 Ro	undvie	w Road	l, Balt	imore,	Md	. 21225
re, s l au of Heal If item		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	cremato	ry or other p		· 1	Date	20c. Location -	,	, -
Baltimore, permit Pages I au Department of Hee Important: If ite injury or other tr		4 Denation 5 Other Specify:		MD Na							aryland
Baltimo permit Pag Department Important:		24. Thature of Funeral Sortios Loons	Malho	Daf	Est	e and Address of ep_Bro	others	Funera e,Balt	1 Home		04045
Physician	-4	23a. Part I Anter the disease, or compli		death. Do no	enter the m	ode of dying, su	LW PIAC uch as cardiac or	r respiratory arre	1more, st, shock, or hea	art .	21217 Approximate Interval
/Medical Examiner		failure List only one cause on each Immediate Cause (Final disease a	nune. Hypertensive Ather	osolerotic	Cardiova	scular Dise	ase				Between Onset and Death
con la		or condition resulting in death)	ue to (or as a consequer	nce of):							
	je		Due to (or as a consequer	nce of):			<u>-</u> -			\rightarrow	
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), be exe sician a	Medical	UNPENDED	AMENDED								
3760, ificate be g physici		IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcome of		Fetal de	eath 3	Ectopic pregna	ncv	23d. Date of Month	delivery Day	y Year
Box 687 e death certifi- the attending	iciai	past 12 months?	4 Pregnant at time	of death 5	H	(Specify)	_cotopio pregna	il Oy	Worter	Day	y real
Bo he dear the at	Physiciar	1 Yes 2 No 9 V Unknown	9 Unknown					Loo- Bidi			(1-110
P.O. s that the	ğ	Part II. Other significant conditions	contributing to death but	not resulting	in the under	riying cause giv	ren in Parti,	r			e cause of death?
ords, F	Completed							24a. Was a	n 24b. V	Vere autor	osy findings available
cor e law r e has b ge 2 sh	du							autops perforr	ned? d	eath?	npletion of cause of
tal Rec	ပ္ပ	25. Was case referred to medical				26.Place o	f Death (Check o	1 Yes 2	No 1	✓ Yes	2 No
Vita ysicia this cer	0 B		ospital: 1 Inpatient	2 ER/OL	tpatient 3		4	g Home 5 F	Residence 6	Other: S	icene
ding Ph After t funeral	i i	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. 1	ime of Injury			28d. Describe ho	w injury occurre	∍d	
Sion vittend death ctor: y the f	atio	2 Accident Spending Investigation					s 2 No				
Division of Vital Records, P.O. pital or attending Physician: The law requires that thours after death eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 Could not b	e 2Be. Place of Injury - (Specify)	At home, fa	rm, street, fa	ctory, office bui	lding, etc.	28f. Location (St or Town, Sta		r or Rural	Route Number, City
Division Hospital or Attent 24 hours after death Funeral Director:	2	4 Homicide 29a. Certifier (Check only) 1 Certifying Physicia	in: To the best of my kno	wledge, dea	th occurred a	at the time, date	and place, and	due to the cause	(s) and manner	as started	1
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transit	edical	one) 2 Medical Examiner:	On the basis of examinat and manner stated								
F 5 F 0	Ž	29b. Signature and title of certifier				29c License			29d. Date signe		, Day, Year)
			mis	W ===		O.C.M	l. c .		August 1, 2	.006	
N		30. Name and address of person who co Ling Li, MD Assistant Me		. ,	Street, E	Baltimore, M	ID 21201				
F (1) 1 1	ate	31. Date filed (Month, Day, Year)	32. egistrar's Si		1 10	2 2					
Regis	trar	AUG 0 3 200	6 Kleaner	15	GDBARE	1					

		1 - For Registrar 1. Decedent's Name (First, Middle, Last	1	Ce	rtificat	e of Death	2. Date of Deat	g. No. 4 U	Ub 243
Physicia /Medic		Jane Harris	,				Month	Day 3, 2006	Year 9:42 PM
Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or Location of Dea	ath	4c. County	of Death
		6601 N. Charles S				altimore		<u> </u>	
Funeral		5. Social Security Number 6. Se.	x 7.Age]M 2√2√7 F	(In yrs. last birthday,	Months		(Month, Day,	Year)	Birthplace (State or Fore Country)
Director		215-80-9466	Λ	46 Yrs.	11		May 6,	960 1	Maryland
me 23a or 28a-f show citival be richified at		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Lin
Tied Tied	ţo	MD		Baltimor	e				1½ Yes 2□
or Iteme 23a or 28a-f show Indigermast be notified at	Director	10e. Street and Number 2910 Wynham Road	#C		10f. Zip	Code 21216	11	g. Citizen of W	
DIRECTIONS.	era	11. Marital Status	12. Was Decedent E	ver in U.S. 13	Was Decer		Specify Ves or No-	14 Bace	USA - American Indian,
20.0	Funerai	1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☒ No	,	If Yes, spec	dent of Hispanic Origin? (offy Cuban, Mexican, Pue	rto Rican, etc.)		k, White, etc.
1	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2∏ No Specify:		Specify:	white
aumatic event, It's Medical Exacting	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	kind of wo	al Occupation	orkina	6b. Kind of Bus	siness/Industry
e Mu	mpi	Elementary/Secondary (0-12)	College (1-4or 5+	life	DO NOT us	se retired)			
n, iii	ပိ	12 17. Father's Name (First, Middle, Last)	<u> </u>		song	gwriter	ame (First, Middle, M		usic
C OV	Be C	Edgar A. harr	is Sr				en Flecke		•
met	٦	19a. Informant's Name/Relationship (Ty		19b. Maili	na Address	(Street and Number or F			
r other traumatic e		Ann Hurleypalmen	c/cousin			field Court			
or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 F		20b. Place of Dispo cemetery, cre	osition (Nan matory or o	ne of ther place)	Date 2	0c. Location - 0	City or Town, State
njury		4 X Donation 5 ☐ Other (Specify) 21. Signat → Funeral Selvice Licens	· · · · · · · · · · · · · · · · · · ·	1 2	2 Name on	d Address of Essilia			
Important: If Ite any Injury or ot QDCs:		Ronald S V	Jaggy Jaggy	or St	tate A	d Address of Facility Anatomy Boar		Baltimo	re Street
		23a. Part1. Enter the disease, or compl	ications mat caused t	he death. Do not en	altimo ter the mod	ore, MD 212 e of dying, such as cardia	O I ac or respiratory arre	st,	Approximate
cian		shock, of heart failure. List only or Immediate Cause (Final	ne cause on each line						Interval Between Onset and Death
lical		disease or condition resulting in death)	Due to (or as a	consequence of):	CT/			-	monta
ner									
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of).					
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	ai Ex	resulting in death) cast	Due to (or as a	consequence of):					
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	by Physician/Medi	IF FEMALE:	3c. If yes, outcome o	foregoanov					
for use as the	cian	in the past 12 months?	1 Live birth 2 4 Pregnant at ti	Fetal death 3	☐Ectopic pro			23d. Date Mont	of delivery th Day Year
De LO	ysi	1 ☐ Yes 2 Ø No 9 ☐ Unknown	9□ Unknown	30	_ Other (apr	50ny)			
be detached	y P	Part II. Other significant conditions con	ntnbuting to death but	not resulting in the u	nderlying ca	ause given in Part I.	23e. Did tob	cco use contrib	oute to the cause of death?
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should	Completed						24a. Was an		ere autopsy findings availal
page 2	Eo						autopsy perform 1 Yes 2	ed? pr	ior to completion of cause o ath? □ Yes 2 □ No
tor.	BeC	25. Was case referred to medical				26. Place of De	eath (Check only one		7 (65 2 140
ral director, pag	10	examiner? 1 ☐ Yes 2 ☐No	lospital: 1 🗌 Inpatient	t 2 ER/Outpatier	nt 3 DO	A Other: 4 ☐ Nursing	Home 5 ☐ Resider	ice 6 20 0ther	(Specify) hospin
g		27. Manner of Death 12 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	f 2	Bc. Injury at Work?	28d. Describe how	v injury occurre	d
	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 ☐ Yes 2 ☐ No			
î	Certification;	4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	reet, factory	, office	28f. Location (Str. City or Town,	et and Number State)	r or Rural Route Number,
aly filled	edicai C	29a. Certifier Certifying Phys	sician: To the best of	my knowledge, deat	h occurred a	at the time, date and place in my opinion, death occ	e, and due to the car	use(s) and man	ner as stated.
ple	Med	uney	and manner state	ed.					
E 1	_	29b. Signature and title of certifier	0			DS8303		-	(Month, Day, Year)
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E GS		76,000						_/	/ 00.0
within 24 hours after death. To the Funeral Director: A completely filled in by the tr		30. Name an address of person who co	empleted cause of dea	ath (Item 23a) (Type,	Print)) 58303 - St Ba	52	10 21	7.07.0

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 26375 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Year Physician 30, 2006 William Houck, Sr. Ju1y 7:45P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College Manor Lutherville Baltimore | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb 21, 1906 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 100 Yrs. Director Maryland 214-10-3648 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mantal Hygiene. 27 is marked other then "naturel", or lieme 23a or 28a-f ehov treumatic event, the Mudical Expris as must be notified at 1 ☐ Yes 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen ol What Country? 21204 615 Chestnut Avenue USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned 1 ☐ Yes 2 ☑ No Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Manufacturer's Representative J.H. Electronic Sales 02 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental H is marked of Houck Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 1205 Oak Croft Drive, Lutherville, MD James W. Houck, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of the important: if its eny injury or ot once. 8/5/06 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns. Timonium, Maryland 21 S nature Funeral Service License Bryan W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 23a. Part1. Inter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) the fusfatic CANCER. of unknown to (or as a consequence of): Primary Source Physician Week 5 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an 1 Yes 2 PNo of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1; King Facility Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To To the Hospitel or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time ol Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the bast of my knowledge ideath occurred at the time, date and place, and due to the dauso(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 1, 2006 Arothy Rely, uns 1)25205 30. Name and address of person who completed of death (Item 23a) (Type, Print) N. Chales St. Bato. Md 2120 W. A. Riley 6701 binc 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar AUG 0 3 2006

			State of Maryland /	Department of Health a Certificate of Death	nd Mental Hyg	
,	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last) PAULA JACQUELINE BROWN JOHN 4a. Facility Name (If not institution, give street and number) 3505 POWHATAN AVENUE	NSON 4b. City, Town, or Location of BALTIMORE	Death	3. Time of Death 10:12PM 4c. County of Death N/A
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 53			
	death with the Maryland me 23a or 28a-f ehow month be notified at	ctor	MD N/A BALT	wn or Location FIMORE CITY		10d. Inside City Limits 1 □XYes 2 □ No
	th with the	al Dire	10e. Street and Number 3505 POWHATAN AVENUE	10f. Zip Code 2121		0g. Citizen of What Country? USA
0030	be filed within 72 hours after death with the Marylar at all typiene. deathylienen "natural", or lieme 23a or 28a-1 show other then "natural", or lieme 23a or 28a-1 show event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Sive Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☑ No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
0-61717	l within 72 ho iene. r then "natur ine Medical	Completed		a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired) LAUNDRY HOSPITA.		16b. Kind of Business/Industry MEDICAL/HOSPITAL
yland		To Be C	17. Father's Name (First, Middle, Last) WHIT HARVEY	CHR		RIE STONES
, Mar	s 1 and 2 should f Health and Mer item 27 is marke other treumatic			b. Mailing Address (Street and Number 3505 POWHATAN A		
IIIIore	Page ment o ant: If ury or		Waurial 2 □ Cremation 3 □ Removal from State MD VI GARR	ISON FOREST	/4/06	20c. Location - City or Town, State OWINGS MILLS, MD
Dan	permit. Depart Import eny inj		21. Signature of Juneral Service Licensee	22. Name and Address of Facility 4600 LIBERTY	TIOMEDE E	UNERAL HOME 21207 V, BALTIMORE, MD
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/en,	eath certificate be executed attending physicien and for use as the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence d.	o of):		
O. Box 68	the death certificat y the attending phy Iched for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Onknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
cords, r	requires thet the death een signed by the atter hould be detached for u	ted by PI	Part II. Other significant conditions contributing to death but not resulting	in/he underlying cause given in Part I.	23e. Did tob	oacco use contribute to the cause of death?
Hec	The law ate has b page 2 st	Completed	bifuse trong metals	gases II	24a. Was ar autops perform 1 🗆 Yes 2	y prior to completion of cause of death?
r vital	nysician nis certif director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Other	of Death Check only one sing Home 5 eside	el once 6 Other (Specify)
ion or	or Attending Physician: ifter death. Director: After this certifica in by the funeral director, g		27. Manner of Death 1 Paratural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	Time of 28c. Injury at Work? 1 Yes 2 N	28d. Describe ho	w injury occurred
DIVISION	To the Hospital or Attent within 24 hours after death To the Funaral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, to building, etc. (Specify)	farm, street, factory, office	28f. Location (Str City or Town	reet and Number or Rural Route Number. n, State)
	the Hospital hin 24 hours a the Funaral hpletely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination a and manner stated.	je, death occurred at the time, date and nd/or investigation, in my opinion, death	I place, and due to the ca h occurred at the time, da	use(s) and manner as stated. ate and place, and due to the cause(s)
•	To the within To the comp	Z	29b. Signature and title of certifies	29c. License number	29	9d. Date signed (Month, Day, Year)
1	5		39 Name and address of person and completed cause of death (Item 23a)	O W. BELVEDENE	AVE BAI	FINANE MD 21215
	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature	Aparles	11061	Him of the

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ronald Wayne Jones 0850 M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WICOMICO SALIS BUR COASTAL HOSPICE THE A-1 LAKE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | May 22, 19 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 € M 2 □ F Yrs. 212-40-8449 65 Director 1941 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ir than "natural", or itams 23a or 28a-f ahow The Medical Examiner must be notified at 1 ☐ Yes 2√2 No Funeral Director Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33363 Perry Hawkin Road 21853 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 2 white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) 8 carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be find Mental Financed of Frank Henry Jones Bessie Feney Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33363 Perry Hawkin Road Princess Anne, MD 21853 Ellen Jones/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ⊠Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street pactor comes Baltimore, MD 21201 a. Pant. Enter the diserve, or complications that caused the death. shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the ettending physicien and I be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ል Yes 2 🗆 No 3 Probably 4 Unknown After this certificete has been sir funeral director, page 2 should? Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes No 1 Yes 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No No Medical Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Oate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pendina М 1 ☐ Yes 2 ☐ No investigation 2 Accident hours efter death unaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a
To the Funaral I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 286. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) asoll, M. Contact 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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	1- Registrar Amend #20b Per FH G858 8/04 C	pantment of Health and Martificate of Death	Reg.	No 000	10 F D
sician	1. Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death 0715 AM
edical	MARY KING 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	JULY .	21 2006 4c. County of Death	0 170 71
miner	SINAL HOSPITAL OF BALTIMORE	BALTIMORE CI	TY	N/A	
ral tor	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 217 40 3177 63 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye OCT • 7	ear) Coui	place <i>(State or Foreigntry)</i> RYLAND
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limit
ŏ	MD. N/A BALTI				1 □XYes 2 □ N
Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
a D	5127 Sekots Road	21207		USA	
by Funeral Director	11. Marital Status 1. Mas Decedent Ever in U.S. Armed Forces? 1. Never Married 2. Married 3. Widowed 4. □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1. □ Yes 3. □ No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:BLA	etc.
	15. Decedent's Education 16a. Dec	cedent's Usual Occupation	166	o. Kind of Business/In	dustry
Completed	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of work . DO NOT use retired)	S	OCIAL SE	CURITY
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) Be	OTTO SCOTT		KENNED		
2		illing Address (Street and Number or Run			o Code)
	RICHARD KING, JR. (son) 903	W. FAYETTE ST.	APT. A	BALTO,	MD.21223
ODES.	₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩	position (Name of rematory or other place) N FOREST VETERA	\pm ,2006	c. Location - City or To DWINGSMI	
900	21. Spriature of Funeral Service Licensee	22. Name and Address of Facility Calvin B. SCRUG	GS FUNE	RAL HOME	
a	23a. Part1. Enter the disease, or complications that caused the death. Do not on the complex of the death.	1412 E. PRESTON	ST. BA	LTO,MD.	21213 Approximate
	shock, or heart failure. List only one cause on each line.		or respiratory arrost,		Interval Between Onset and Death
an al	Immediate Cause (Final disease or condition resulting in death) a. AIRWAY OBST Due to (or as a consequence of):	euction			1 HOUR
er	Anoxic brain injury re	esulting in metabolic ac	ridosis		
ner	if any, leading to immediate cause. Enter Underlying				
Examine	Cause (Disease or injury that initiated events resulting in death) Last c				
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edical	0.				
Physician/Me		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliv Month	rery Day Year
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od by			1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknow
Completed			24a. Was an autopsy performed	prior to co d? death?	opsy findings availab ompletion of cause of
Be	25. Was case referred to medical examiner?		h (Check only one)		
ု့	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa		·	e 6 Other (Speci	(y)
<u></u>	27. Manner of Death 1 Manual 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)		28d. Describe how	injury occurred	
Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
ledical Ce	29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, do 2				
Medical Certification; 7	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month,	Day, Year)
) [RES-DOO		TULY DI	2006
				/ 21	
	30. Name and address of person who completed cause of death (Item 23a) (Tyl	pe, Print)			
	30. Name and address of person who completed cause of death (Item 23a) (Tyl MAYSEL K OBENG MV) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	RES-000 SINA HUSPITAL	OF BA	LTIMORE	

			For State Registrar	State o	of Marylan				ealth a Death	ind Me	ental F	lygier Reg.	900	5	24380)
			Decedent's Name (First, Middle, Last)								2. Date of Month		Day Ye	ar	3. Time of Death	_
	Physicia /Medic			Utta	m Kaur						July				6:30 P M	
	Examin		4a. Facility Name (If not institution, give s	treet and nu	mber)		•		Location of				4c. County of D			
97	4		20300 Stringfellow						ersbu			Dist	Mont	<u> </u>		_
	Funeral		5. Social Security Number 6. Sex	M 2 ∑ F	7. Age (In yrs.	last birthday) Yrs.	Months	r 1 Year Days	If Under 2 Hours	Min.		Day, Ye	ar)	Countr		7
77.	Director	-	216-25-6188 Usual Residence of Decedent		96						Jan l	, 19	10		India	_
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10	d. Inside City Limits	
	Mary	tor	Maryland Montgome	rv			01n	ey							1 ☐ Yes 2 X No	
	or 282	Directo	10e. Street and Number				10f. Z	p Code				10g.	Citizen of What	Count	y ?	
	th will		66 Shadowridge Co	urt					832				United			
	r dea	Funeral	The state of the s	Armed F		.S. 13.	Was Dece f Yes, sp	edent of Hi ecify Cuba	spanic Orig n, Mexican	gin? (Spec , Puerto F	ofy Yes or lican, etc.)	No-	14. Race - A Black, W			
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	1 ∐Yes If Yes, G Year or [ve _		1 □ Yes	⊉ No	Specify:				Specify: A	cia	n-Indian	
Maryland 21215-0036	hour tural		15. Decedent's Edu		Jales.	16a, Dece	dent's Us	ual Occupa	ation			16b	. Kind of Busine			_
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212	with liene.	mo	Elementary/Secondary (0-12) 10th	College (1-40r 5+)		Home	maker					0wn	Hom	ie	
ğ	Hygothe othe	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Mic	ldle, Maid	den Surname)			
<u>ā</u>	uld be Aenta rked ric ev	ToE	Unknown								Unkr	iown				
ar	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Iteme 23a or 28a-f ehow eumatic event, the Medical Exemples must be mailtied at		19a. Informant's Name/Relationship (Ty	oe, Print)			3						ty or Town, Stat		•	
Σ	and 2 palth n 27		Ravi Kaur/granddau	ghter	Tana a	1			Poir			_	keville,			
altimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ R	emoval from	State	Place of Dispo cemetery, crer	natory or	other plac	1		ate		. Location - City			
Ē	Pag ment tent: jury c		4 □Donation 5 □ Other (Specify)		Wes	t Arun						_	denton,			
Bail	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 ie marked ent injury or other treumatic e one.		21. Signatur of Funeral Service Ligens	Jaman Q		14 14	onal 11 A	nd Addres dson nnapo	s of Facility Funer olis F	al H Road	ome 8	creation,	ematory , Maryla	P.	A. 21113	
			23a. Part 1 Inter the disease, or complishock, or heart failure. List only or Immediate Cause (Final							cardiac or	respirato	ry arrest,			Approximate Interval Between Onset and Death 3 days	
1	Physician /Medical		disease or condition resulting in death)		ongestiv		t ra	TTULE	3					+	- days	
*	Examiner		Connecte the lies constitues	Ca	ardiomyc	pathy									5 years	
0	D ==	ner	if any, leading to immediate cause. Enter Underlying	Due to	(or as a consec	uence of):								1		
13	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		ypertens										0 years	
Ö,	e executana	Ä	resulting in death) Last	Due to	(or as a consec	uence of):										
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Box	atten for u	cian	in the past 12 months?	1 Live	birth 2 Feta	aldeath 3□	Ectopic Other (pregnancy specify)					Month		Day Year	
o	that the de led by the a detached f	isic	1 □ Yes 2 🕅 No 9 □ Unknown	9□ Unki												
Division of Vital Records, P.	8 5 0	by Physician/M	Part II. Other significant conditions con	ntributing to	death but not res	ulting in the u	nderlying	cause give	en in Part I.	•	1				a cause of death?	า
20	w require been sig should b	Completed	4								240 1	Man an	24h Was	nutan	ay findinga ayaylabl	_
3ec	The law cate has I page 2 s	lg III									а	Vas an utopsy erformed	prior	to com	sy findings available pletion of cause of	,
a	icien: Th certificate rector, pag		Or Manager Manager	_					00.0	-101	1 🗆 Ye		No 1 🗆	Yes :	2 ∑ No	
⋚	Physicien: r this certifica ral director, p	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital:	Inpatient 2	TER/Outcation	nt 3□ [Oth			(Check or		a 6 NOther (Space for	Grandson' Residenc	3
o	Phy or this oral d	1: To	27. Manner of Death	28a. Date	of Injury	28b. Time o		28c. Injun	y at	2	8d. Descr	ibe how i	injury occurred	opecny,	Kesidenc	e
on	th.: Afte	tloi	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Mo.	nth, Day Year)	Injury	М		k? Yes 2⊟	No						
Divis	or Attending after death. Director: Afte in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plac build	e of Injury - At h ding, etc. (Speci	ome, farm, st fy)	reet, facto	ry, office		2	8f. Location City of	on (Stree Town, S	t and Number o	r Rural	Route Number,	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical Co	29a. Certifier 1 ▼ Certifying Phy (Check only 2 ■ Medical Exami	ner: On the	basis of examina											
	To the billion 2. To the billion 2. Complet	Med	one) 29b. Signature and title of certifier	and ma	nner stated.		2	9c. Licens	e number			29d.	Date signed (N	lonth. E	Day, Year)	_
	To To Con	-	1 10	An t	Ha n.	D	-					1	August			
	0		30. Name and address of person who co	moleted on	ise of death (Ita	7/ m 23a) /Turon	Print1	טטע	47707				August	19	2000	
	1		Rita Pabla, M.D.		Baltim			Lau	rel,	Mary:	land	2070	7			
1.00	St.	ate	31, Date filed (Month, Day, Year)	32.	gistrar's Sign	ature								·		
13	Regist		AUG 0 3 20	06	Wallet B.	18 1	SAL	,								

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death L Decedent's Name (First, Middle, Last) Month Year Physician 07 - 28 - 068:05 P M Eugene Gilbert Kramer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner N/A Raltimore Bon Secours Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months Maryland 13X M 2 ☐ F 76 214-26-6086 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County tem 27 is marked other than "natural", or itams 23s or 28e-f show other traumatic avant, the Madical Examinar must be multiled at Baltimore MD N/A 1 No 2 No Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21223 U.S.A 1228 Glyndon Ave by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene Important: if Item 27 is marked other than "natural", or Item any injury or other traumatic avant, the Madical Exempted 2008. 1 Never Married 2 AMarried Specify: White altimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Carr Lowrey Elementary/Secondary (0-12) College (1-4or 5+) Glass Company Mold Setter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bertha Lebon Charles Raymond Kramer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1228 Glyndon Ave. Baltimore MD 21223 James Greene/Son-in-Law 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial
Park 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal/from State 8-3-2006 Elkridge, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Librose Funeral Home, Inc.
1328 Sulphur Spring Rd. Arbutus MD 21227 21. Signature of Funeral Service plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final Acure MYOCHERIA MIADETION Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ATPIAL FISHUMTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner I Records, P.O. Box 68760, C AISENS 2 ATTEROSCILLATOTIC Diouns cuch use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician SUM-W-C IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 CAZEINOMA 1 Yes 2 No 3 Probably 4 Dunknown icate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 🗌 Yes certificate To the Hospitel or Attending Physician: After this certification funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 X ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) yd ui bellil 4 - Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 29d. Date signed (Month, Dev. Year) 29c. License number ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and POWS my WIRMMUTON M-WINSTON 300 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 0 3 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** · 23 DM Leonard Bernard Loewer 06 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimort Square 6. Sex 7. Age (In yrs. last birthday) tranklin If Under 1 Birthplace (State or Foreign Country) 5. Social Security Number Year 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min XXM 2□ F Yrs 78 Director 216-20-6306 Maryland Oct. 30,1927 Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits r then "naturel", or Items 23s or 28s-f show the Wedical Examiner must be notified at 1 ☐ Yes 200 No Rosedale Maryland Baltimore Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1 4886 Bright Leaf Court 21237 United States deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married 21215-0036 1 ☐ Yes 2 No Specify: Specify þ 3 SWidowed 4 □ Divorced ear or Dates: WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Electronic Engineer Civil Service 4 Years is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Mental Catherine Walters ပ Leonard Loewer 19a. Informant's Name/Relationship (Type, Print) (Friend) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit Pages 1 and 2 s Department of Health ar Important: If item 27 is any in ury or other trau 4878 Bright Leaf Court Rosedale, Maryland 21237 Dr. William Jones Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Holy Rosary Cemetery 7/27/2006 Dundalk, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bal Duda-Ruck Funeral Home of Dundalk, Inc. 0 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CORONARY ARIERY DISEASE Immediate Cause (Final disease or condition resulting in death) **Physician** JIII /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2K) No 1 ☐ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 x Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident **Director**: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Caminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature an RES DOC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Frankin Squarfdr. Bothmire, D. 2 237 THHOCENE Morya-Tombi 31. Date filed (Month, Day, Year) 32. Apgistrar's Signature State South Registrar AUG 0 3 2006

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 19a per int 858 8-7-06 vt.

Amend #10e Per FH G858 8/03/06-JH

Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 0245am ANSE DOLORES 2006 46457 /Medical hon dall 5 town

If Under 1 Year If Under 24 Hrs.

Nonths Days Hours Min.

Nonth, Day, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultimore HOSDITA Birthplace (State or Foreign Country) 5. Social Security Number 219.32 00 8. Usual Residence of Decedent 7. Age (In yrs. last birthday).
Yrs. **Funeral** 1 M 200 F Year) Months ML Director with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iteme 23a or 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "naturel; or iteme 23a or 28a-f ehov any injury or other traumatic event, ite Madical Examinar must be notified at 1 | Yes 2 | 0 Ba Himore Owings mills Directo 101. Zip Code 10g. Citizen of Whal Country? Choice 10e. Street and Number Owings chase ct Funeral 12. Wee Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 ☐ Widowed 4 Divorced Completed 16a. Decedenl's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Social Security College (1-4 or 5+) Elementary/Secondary (0-12) Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be 19a. Informant's Name/Relationship (Type, Print) -in-law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Elaine Lansey Daughter owingsmills MD 21117 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount 3 06 Baltimore. MD 22. Name and Address of Facility Caughn C. G recre funeral Service 21. Signature of Funeral Service Licensee pnce Yaylun C. Grae 8728 Litzing Wa Randoulstown Miles 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8728 Liberty Rd mo Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HSCVD Physician /Medical Due to (or as a consequence of): Examiner HIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.
To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit completely filled in by the funeral director, page 2 should be detached for use as the burial transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? ፩ 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an aulopsy performed? Yes 2 No 1 ☐ Yes 2□ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: 1 ☐ Inpalient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dr. Lang Harren HOOS1339 August 1,2006 b 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Ct Rd. Kundallstown MD 2/133 5401 Drumatarken 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 3 2006 Registrar

			1 - For State Registrar	State of M	larylan		artmen rtificat			and M		Reg. No.	006	24,384
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Baltimore,	Pages 1 nent of H int: if ite		20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □		. 0	emetery, crer	natory or o	ther plac	ADIZ A	.UGUŠ 2006		20c. Location	,	
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	D D		Usual Residence of Decedent	, 00			100.00.		
ab.	Aarylar I ehow	ō	10a. State 10b. County	1.	Town or Location	5 - 20 - 200			10d. Inside City Limits 1 ☐ Yes 2 No
Manns	is 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If the alth and Mental Hygiene. If marked other then "naturel", or iteme 28s or 28s-f show other treumatic event, its Medical Examinar mast be notified at	Funeral Director	10e. Street and Number	timore	Candalh 101. Zi	o Code	10g.	Citizen of What Cou	, v
£	eath w	eral	3447 Carriage	12. Was Decedent Ever in U.S.	13 Was Dece	odent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ameri	can Indian.
ر ا	after d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 KiNo	If Yes, spe	edent of Hispanic Origin? (Secify Cuban, Mexican, Puerl	to Rican, etc.)	Black, White,	, etc.
Belind 15-003	hours a	d by	3 ☐ Widowed 4 Divorced	Year or Dates:			1.00	Specify: 6	ack
Belinde	n nat	plete	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	college (1-4or 5+)	16a. Decedent's Usu (Give kind of w life. DD NOT u	ial Occupation ork done during most of wo use retired)	rking	. Kind of Business/Ir	ladistry
a.s	filed with Hygiene other the	Completed	12th			erK,	9	tate of	Maryland
Maryland	d be fill intal H. ed oth	Be	17 Forther's Name (First, Middle) La	si)		18. Mothers Nar	ne (First, Middle, Maid	ien Sumame)	1
900	should and Men marke umatic	ဥ	19a Informant's Name/Relationship	(Type, Print)	19b. Mailing Addres	s (Street and Number or Ru	ur I Rhute Number, Cit		
_	and 2 ealth a m 27 lo	(anns Daughter	3447 (a	rriage Hill (Jr. A. 71		wn ND 21133
atient	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3	Removal from State	ace of Disposition (Na metery crematory or	other place)	1 . + 1	Location - City or T	own, State
tient	permit. Pages Department of Important: If I eny injury or on		4 □ Donation 5 □ Other (Special Service Lice		en Marin	and Address of Facility	12006 d	L'INTERIOR	re, 1 All
2 G	permit. Departr importr eny inj		Naughu ("	Sheene	51517	3alfmore 1	att. Pike	Balto, M	D 21229
			23a. Part1. Enter the disease, or co shock, or neert failure. List on	mplications that caused the death by one cause on each line.	. Do not enter the mo	de of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Assistation as a consequ		nonia			12 days
	Examiner		Convertingly list conditions	b.	ience or).				10
•	₽ W is	lner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):				
	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	ience of):				
760	ate be execut			d					
Š	Sentifica ding pl	/Med	IF FEMALE:	23c. If yes, outcome of pregnar	ncv			23d. Date of deliv	ion.
ä	death death	Physician/Medical	23b. Was decedent pregnant in the past 12 menths? 1 \(\sum \) Yes \(2 \sum \) No	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic p			Month Month	Day Year
0	at the	Phys	9 Unknown	9□ Unknown		in Dead	22a Did tahaa	no una anatributa ta l	the server of death ?
A you of Wite Boards D G	Attending Physicien: The law requires that the death certificate be rideath. ector: After this certificate has been signed by the attending physicie by the funeral director, page 2 should be detached for use as the bur	2	Part fl. Other significant conditions		iting in the underlying	F.		co use contribute to I	
Š	s beer shou	Completed					24a. Was an	24b. Were auto	opsy findings available ompletion of cause of
å	The ta	mo					autopsy performed	2 death?	
41	iclan: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospitaf:			ath (Check only one)		
•	Phys r this orat dir	7.	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospitaf: 1 ☑ Inpatient 2 ☐ I 28a. Oate of Injury (Month, Day Year)	ER/Outpatient 3 □ D 28b. Time of	28c. Injury at Work?	dome 5 ☐ Residence		(fy)
2	ath. r: Afte	atlor	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	Injury M	Work? 1 ☐ Yes 2 ☐ No			
9	or Atter de after de Directo	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Pface of frierry - At ho building, etc. (Specify	me, farm, street, facto	ry, office	28f. Location (Street City or Town, St	t and Number or Rur tate)	al Route Number,
C	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	al Ce	29a. Certifier 1 Certifying	Physician: To the best of my know	wledge, death occurre	d at the time, date and place	e, and due to the cause	e(s) and manner as	stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only 2 Medical Ex	raminer: On the basis of examinat and manner stated.		n, in my opinion, death occu			
	with To t	Σ	29b. Signature and title of certifier	I. Date signed (Month, Day, Year)					
	n		Orene 140 30. Name and address of person w		23a) (Tune Print)	RES-000		July 31	,2006
)		Irene Hac	, MD Sinai	Harlo Hal	of Baltim	ore		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar' Signal	A STATE OF THE STA				
	Regist	ar	2000						

			For State Registrar	State of Maryla		artment rtificate			d Mental Hy	gien Reg. No	Z U U D -	24387	
4.4	Physici		1. Decedent's Name (First, Middle, Last) Louise Matheson					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2. Date of Do Month Aug.	Da	ay Year	3. Time of Death 9:00 A. M	
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, T	Town, or I	Location of De		_	. County of Death	7 3 . 00 1.	_
			12233 Carroll Mil					City			Howard		
	Funeral Director		5. Social Security Number 6. Sex 192–18–3451	7. Age (In yrs 82	. iast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 H Hours N	Irs. 8. Date of Bi (Month, D		9. Birth Cou	place (State or Foreign ntry)	_
	ow ow		10a. State 10b. County	10c. C	ity, Town or Lo	ocation						10d. Inside City Limits	_
	Man,	tor	MD Howard	E1.	licott	City						1 □ Yes 2 No	
	or 28	Director	10e. Street and Number			10f. Zip	Code			10g. C	itizen of What Cou	ntry?	
	ath w	ra F	12233 Carroll Mil				1042		(2)		USA		
ဖွ	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f ehow tan Alcal Exemitant mast be mailled at	Funeral	1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 14 Yes 2 □ No 194 If Yes, Give	¥5	Was Decede If Yes, speci 1 Yes 2		spanic Origin? i, Mexican, Pu Specify:	(Specify Yes or Nierto Rican, etc.) white	0-	14. Race - Ameri Black, White, Specify: Whi	etc.	
Maryland 21215-0036	hours ural',	d by	3 Widowed 4 □ Divorced	Year or Dates: 194	+6	dent's Usual				1.Ch .			_
7	in 72 n "nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give		k done du	uring most of	working	100.7	Cind of Business/In	adustry	
212	d with giene er tha	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)	Wait	ress				Re	estaurant	-	
nd	be filed v tal Hygie d other i	Be	17. Father's Name (First, Middle, Last)					18. Mother's I	Name (First, Middle	, Maide	n Sumame)		
<u>y</u> a	Men Men Marke Marke	2	Victor Smith	2:4	405 44 5		(2)		aret Sasc			2.71	
<u>a</u>	d 2 st th and th and traum		19a. Informant's Name/Relationship (Ty) John Matheson - Se						Rural Route Numb	-			
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, It a Modical Examination may be notified at ADGS.		20a. Method of Disposition 1 Burial 2 Cremation 3 R	20b.	Place of Dispo cemetery, crei	sition (Nam	ne of		Road Elli Date	20c. L	ocation - City or To	own, State	
Ē	t. Pag ntment ntant:		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice Se		etro Cr			Au	g. 2, 06	Bal	timore,	MD	_
Ba	Depa Impo any ir		WW A	Manau		Crema 299 F	tion rede	Socie	ty of Mar Dad Balti	ylar more	nd, Inc.	8	
	Physician		23a. Pagh. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deale cause on each line.	th. Do not ent	ter the mode	of dying	, such as care	BLADD	arrest,		Approximate Interval Between Onset and Death S Menths	
58760,	Physician: The law requires that the death certificate be executed to this certificate has been signed by the attending physicien and train director, page 2 should be detached for use as the burial-transit to the control of the con	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse Due to (or as a conse Due to (or as a conse	quence of):								_
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3[⊒Ectopic pre ⊒ Other (spe				4.6	23d. Date of deliv Month	ery Day Year	
Records, P.O.	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	inderlying ca	ause give	n in Part i.				he cause of death?	
Reco	The law re ate has bee page 2 sho	Completed							24a. Wa: auto perf 1 Yes	psy ormed?	prior to co	opsy findings available impletion of cause of	
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	de estado			0.5		Death Check only	оле)	201		
of o	Physi this c	5 7	1 Yes 2 No 27. Manner of Death		ER/Outpatier 28b. Time o			4 🗀 1401 5111	g Home 5 Res			fy)	_
on	Attending in death.	ation	1 Patural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	м	8c. Injury Work 1 🔲 Y	? es 2 □ No	254. 25551155	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.,		
Division of Vital	i ji ji e	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At building, etc. (Spec	nome, farm, sti ify)	reet, factory,	, office		28f. Location City or To	(Street a	nd Number or Run e)	al Route Number,	_
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (29a. Certifier 1 Certifying Physical Control only 2 Medical Examination	sician: To the best of my kr ner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred a vestigation,	at the time in my op	e, date and pl inion, death o	ace, and due to the courred at the time	cause(s , date ar	s) and manner as s nd place, and due t	stated. o the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	٨		29c.	License	number	250	29d. Da	ate signed (Month,	Day, Year)	
)	111		MeidH	chemo			2	C7 88	28	Ac	igust à	2 2006	
	611		30. Name and address of person who co	empleted cause of death (Ite	m 23a) (Type,	Print)	50 1	KNOLL	N Dr:	Cal	UBBIA	2 2006 mo 2040	(-
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 3 20	32. gistrar's Sign		mile							-

	1	State of Maryland / Dep State of Maryland / Dep Registrer Ce	artment of Health and M rtificate of Death		ene 2006	24388
*		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
Physicia		Russell Brodis Mason, Sr.		August	1, 2006	10:45A M
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deal	th
		152 Hobbitt Lane	Pasadena		Anne Art	undel
Funeral Director		5. Social Security Number $\begin{array}{cccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, YO 7/28/1	9. Bird 928	thplace (State or Foreign buntry) MD
pu *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
aryla •ho	5					1 ☐ Yes 2 🛣 No
the N	Director	MD Anne Arundel Pasade	10f. Zip Code	100	g. Citizen of What Co	ountry?
with Se or		152 Hobbitt Lane	21122		U.S.A.	·
leath na 23 mus	Funerai		Was Decedent of Hispanic Origin? (Sp. II Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	erican Indian,
ING 21215-UU36 be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23s or 28s-f show event, the Medical Examinat must be notified at	by Fun	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married Forces? 1 Never No. 1946 − 1 Never Married 2 Married Forces? 1 Never No. 1946 − 1 Never Married 2 Married Forces? 1 Never No. 1946 − 1 Never Married 2 Married Forces? 1 Never No. 1946 − 1 Never No.	II Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Specify: W	hite
Maryland 21215-0035 nd 2 should be filed within 72 hours af the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam			edent's Usual Occupation	16	6b. Kind of Business	/Industry
Z TS	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ing		
d with	E		ractor		Constr	uction
other of the	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
Nat Wild by Menta Aenta Menta	To E	Andrew Dorsey Mason, Sr.	Margar	et King	ſ	
re, Marylanc s 1 and 2 should be 1 f Health and Mental I frem 27 ts marked of other traumatic eve	- 0	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ing Address (Street and Number or Rura	al Route Number, (City or Town, State, 2	Zip Code)
B, Ma l and 2 fealth a im 27 to her tra		Katherine Mason / Wife 152	Hobbitt Lane,		a, MD 2	1122
of Hear		20a. Method of Disposition 1 28 Burial 2 Cremation 3 Removal from State	osition (Name of amatory or other place)	Date 20	c. Location - City or	Town, State
Baltimore, permit. Pages 1 ar Department of Heal Important: if Item?		4 Donation 5 Other (Specify) Glen Ha	ven Mem Pk 08/0	4/06	len Bur	nie, MD
Balt permit. Departr importa eny inju		21. Signature of Euneral Service Licensee	2. Name and Address of Facility G_{ullet}	.Gonce	Funeral	Home, PA
w 89 2 2	1 19	/24/2 1	69 Riviera Driv	re, Pasa	dena, M	D 21122
		23a. Part1. Enter the disease, or complications that caused the death. Do not el shock, or hear failure. List only one cause on elich line.	nter the mode of dying, such as cardiac	or respiratory arres	it,	Approximate Interval Between
Physician	e ly	Immediate Cause (Final disease or condition	ling conce	~	98	Onset and Death
/Medical		resulting in death) a. — Due to (or as a consequence of):	O conse			
Examiner		Sequentially list conditions, b.				
ב ס ו	Examiner	riany, leading to immediate Due to (or as a consequence of).				
ecute and trans	am	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
8760, ale be executed hysicien and the burial-transit	<u> </u>	resulting in death) Last Due to (or as a consequence of):				
	dical	d		<u> </u>		
Box 68 eath certifice attending pt	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			and Date of de	
Box eath cert attendin for use	ian	in the past 12 months? 1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	Day Year
O. the de ached	ysic	1 Yes 2 No 9 Unknown	- Other (specify)			
P.O. that the de ed by the detached	F	Part II, Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Division of Vital Records, P.O. Box 6: or attending Physician: The law requires that the death certific after death. Director: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as	ted by			1 ☐ Yes	2 □ No 3 □ Pi	robably 4 Vunknown
Reco	Completed			24a. Was an autopsy	24b. Were at prior to	utopsy findings available completion of cause of
The the pege	Son			performe 1 ☐ Yes 2		2 □ No
f Vital Re(ysician: The la is certificate has director, pege 2	Be	25. Was case referred to medical examiner?		n (Check only one)		
of value of	မ	1 Yes 25 No Hospital: 1 Inpatient 2 ER/Outpatie			ce 6 □Other (Spe	ocify)
ing P	on:	27. Manner death 28a. Date ol Injury 28b. Time (Month, Oay Year) Injury Injury	Work?	28d. Describe how	ulinia occurred	
VISION Of VIta Attending Physician: r death. ector: After this certifici by the funeral director, i	cat	Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of Injury. At home farm s	M 1 Yes 2 No	201 Location /Care	at and Mumber of C	-10
Divi	Certification:	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, so building, etc. (Specify)	treet, lactory, office	City or Town,	et and Number or R State)	urai Houte Number,
Hospitel Hospitel Hours Funeral	edicai C	29a. Certifier (Check only) 2 Medical Examiner: On the basis of examination and/or and manner stated.				
To the twithin 2.	Med	29b. Signatule and title of certifier	29c. License number	290	d. Date signed (Mont	th, Day, Year)
8 4 5 4		NA A	Dulcaz	_	8/2/1	,
A 1		On No. and advantage of a completed course of death (the CO.) (T.	Orint)		9 3/0 5	ρ
XX		30. Name and addless of person who completed cause of death (Item 23a) (Type	Marshin DI	20.		7.1179
Sta	to	31. Date filed (Month, Day, Year) 32. Registrar's Signature	IIM DAIN TOUR	MANGE	a m	
Regist		AUG 0 3 2006	Coarle			

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			1 - State	State of Mar		artment of F rtificate of I				24389
10-			Registrar 1. Decedent's Name (First, Middle, Last)		007	tinoato or i	Douth	2. Date of Dea	Reg. No.	3. Time of Death
	Physici /Medic		Elizabeth A. Nelke	r				Month 08	Day Year 01 200	D.
	Examir		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Deat		4c. County of Dea	ath
			8113 Loch Raven Bl			Towson	T 1/11		Baltimor	
	Funeral Director		5. Social Security Number 6. Sex 213-26-3256	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 03/08/	7 Year) 9. Bi 1928 Mar	rthplace (State or Foreign ountry) 'yland
	yland now		10a. State 10b. County		Oc. City, Town or Lo	cation				10d. Inside City Limits
	a-f st	ctor	MD Baltimore		Towson					1 X Yes 2 ☐ No
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show disal Examinal must be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	s 23a	rai	8113 Loch Raven Bl			21286			U.S.A.	
	iten de	Funerai	11. Marital Status 1 ☐ Never Married 2 ※ Married	 Was Decedent Even Armed Forces? 1 ☐ Yes 2 X No 	er in U.S. 13. 1	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
036	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: W	hite
2-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	dent's Usual Occup	ation	rkina	16b. Kind of Business	s/Industry
121	l within 72 ho liene. r then "netu ine Medicel	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	1)	9		
d 2	be filed v tal Hygie d other t		12 17. Father's Name (First, Middle, Last)		Sec	cretary	18. Mother's Nar	ne (First Middle	Governmen Maiden Sumame)	t
an	ad la b	To Be	George Rist					Harriso	•	
Maryland 21215-0036	d 2 should th and Men 7 is marke traumatic	-	19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailin	ng Address (Street			r, City or Town, State,	Zip Code)
Σ	1 and 2 Health a em 27 is		Charles F. Nelker				en Blvd.	Towson,	Maryland:	21286
Baltimore,	T of or		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re		20b. Place of Dispo Dulaney Val	sition (Name of natory or other place	201	Date	20c. Location - City o	Town, State
ţ	E 0 3		4 ☐ Donation 5 ☐ Other (Specify)			_	1/80	04/2006	Timonium,	Maryland
Bal	permit. Depertmit. Imports any inju		21. Signature of Funeral Service License	θ		. Name and Addres	E.	eonard J	. Ruck, In	C.
4	71	7	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused th					e, MD 2121	Approximate
100	Physician		Immediate Cause (Final	e cause on each line.	-n im20	Para a	ooida	+ (1:	(1)	Interval Retween
7	/Medical Examiner		disease or condition resulting in death)	Due to (or as a c	consequence of):	car o	aruer	n Cov	(A) disease	1-en hours.
ą.	Examiner		Sequentially list conditions b.	Hype	rtensiv	e Car	diovas	Rular	disease	yr.
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to lo as a c	onsequence of):					· ·
•	xecut	Examiner	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):					
760,	eath certificate be executed attending physician and for use as the burial-transit	caiE			,					
99	tificat g phy as the	ledic								
Вох	th cer tendir r use	Physician/Medi	23b. Was decedent pregnant	lc. If yes, outcome of 1□Live birth 2 [Ectopic pregnancy			23d. Date of de	
	he dea the at hed fo	/sici	in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	4☐Pregnant at tin 9☐ Unknown	ne of death 5□	Other (specify)			Month	Day Year
P.0.	The lew requires that the death certifica lie has been signed by the attending ph page 2 should be detached for use as th		Part II. Other significant conditions con	tributing to death but r	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
Division of Vital Records,	uires n sign lld be	d by	Hypothyroc	4				1 🗆 Y	es XNo 3□P	robably 4 Unknown
CO	s been si	Completed	History o	D-cance	er-cole	m ren	noved.	24a. Was a		utopsy findings available
R	The lew cete has page 2 s	luo:							med? death?	compfetion of cause of
ital		Be C	25. Was case referred to medical examiner?	7.00			26. Place of Dea	th Check only or	710-7-1-1	20110
<u>></u>	Z 2	2	1 ☐ Yes 2 No	ospital: 1 fnpatient	2 ER/Outpatien		4 🗆 Nul sing n	ome 5 Reside	ence 6 □Other (Spe	ecify)
ou c	Jing F	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of fnjury (Month, Day Y	ear) 28b. Time of Injury	28c. Injury Work		28d. Describe h	ow injury occurred	
risi(il or Attending after death. Director: After d in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e, Place of Injury	- At home, farm, stre		Yes 2 □ No	28f. Location (S	treet and Number or R	ural Route Number
Οİ	a after I Dire	Certification:	4 Homicide determined	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , ,		City or Town	n, State)	oral riodic riambor,
	To the Mospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier (Check only 2 Medical Examin	ician: To the best of r	nv knowled e. death	occurred at the tim	ne. date and place	and due to the c	ause(s) and mannor a ate and place, and du	e etatad
	the H iin 24 the F the F	fedical	one)	and manner states	d.					
	To the within To the comple	Σ	29b. Signature and title of certifier	45		29c. License	1799:		9d. Date signed (Mon.	
	47		20 Name and address of access when	noleted enues of deat	h (Item 22a) (Time		1177		01-1	
C	1		30. Name and address of person who cor Khin M. Tun. MD 13				D 21286			
39.5 565	Sta	te	31. Date filed (Month, Day, Year) 200		Signature					
	Registr	ar	MUQ 0 0 2000	July State	Sil Jaga	well.				

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Wark Nathanson	1- For State	Certificate of		Reg. No.	2005	2139					
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	NATH	ANSON	2. Date of Death Month Day July 31, 2006	V	me of Death 702 hrs					
- marin	4a. Facility Name (if not institution, give street		b. City, Town, or Location of Deat		c. County of Death						
funeral	Johns Hopkins Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Baltimore City If Under 1 Year If Under 24Hr	s. 8. Date of Birth (MM)		N/A ce (State or					
Director	294-40-9879 1X M 2	F 58 Yrs.	Months Days Hours Mir	10/11/19	Foreign Country	OH					
v any	10a State 10b. County	10c. City, Town or Locati				. Inside City Limits					
vfaryland 28a-f show 1 at once.	T/A	reet, 3rd Floor c/o	100 Tim Code	10g. Citi	izen of What Country?	Yes 2X No					
th the Maryland 23a or 28a-f sh notified at once al Director	2401 PENNSYLVANIA	AVENUE Berlin	07105 19130		14 December 1	USA					
Baltimore, MD 21215-0036 pennit. Pages I and 2 should be fited within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the <u>Nedical Examiner must be notified at once</u> To Be Completed by Funeral Director	1 Never Married 2 Married 1	med Forces? If Yes 2 X No	s Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puerto		14. Race - American II White, etc.						
us, after turral", aminer	3 Widowed 4 Divorced of Divorced of Date 15. Decedent's Education (Specify only high	s: est grade completed) 16a. Deceden	Yes 2 X No specify: 's Usual Occupation (Give kind of		Specify: Kind of 8usiness/Indusi						
, MD 21215-0036 and 2 should be filed within 72 hours after teath and Mental Hygiene tean 27 is marked other than "natural", traumatic event, the Medical Examiner To Be Completed by 1	Elementary/Secondary (0-12) Co	llege (1-4 or 5+) Resea	ost of working life. DO NOT use re Irch Scientist ICIAN	Don	versity Medic tist. State o MEDICAE Jer	f Nou					
215-0036 be filed within 7 ntal Hygiene riked other than ent. the Medica Be Comple		NATHANGON	18 Mother's Nam	e (First, Middle, Maiden							
2121 could be fil d Mental Is s marked tic event.	HYMAN 19a. Informant's Name/Relationship (Type, Pr		Address (Street and Number or	Rural Route Number, C	ity or Town, State, Zip						
md 2 sho salth and 2 sho sen 27 is raumati	JAYNE NATHANSON /		PENNSYLVANIA AV		LADELPHIA,						
Baltimore, pount Pages I at Department of He Important: If ite injury or other tr	1 8urial 2 Cremation 3 X Rer 4 Donation 5 Other Specify:	WEST LAUR	EL HILL CEM. 08,			,					
Balti permit Departn Import	21. Signature of Funeral Service Licensee	110	ame and Address of Facility 8900 REISTERSTON	SOL LEVINS NN ROAD - P	ON & BROS. IKESVILLE.	, INC. MD 21208					
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease										
Examiner		osclerotic Cardiovascular Dis (or as a consequence of):	ease		-	Death					
ner	Sequentially list conditions, if any, leading to immediate Due to	(or as a consequence of):									
nsit saminer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(or as a consequence of):									
760, icate be executed physician and the burial - transit		NDED#10a-f,16a-b, perF	I 0861 11/14/06 TT								
3760 ificate b ig playsia is the bu	193h Mac decodent progrant in the	If yes, outcome of pregnancy	tal death 3 Ectopic pregr		d. Date of delivery Month Day	Year					
he death certification with the attending the attending ched for use as a Physician?	past 12 months?	Decree at time of death	her (Specify)	1	,						
	_	<u> </u>	inderlying cause given in Part I.		use contribute to the c						
IS, P.(quiros tha en signed uld be det				1 Yes 2 2	No 3 Probably						
Records, The law requires freate has been significate has been significate has been significate has been significate has been significate has been significated.				autopsy performed? 1 Yes 2	death?	etion of cause of					
tal Rector, pa	25. Was case referred to medical		26.Place of Death (Check			2					
of Vit	1 Yes 2 No	a. Date of Injury 28b. Time of I		ing Home 5 Reside	ence 6 Other:						
ion creating teath tour African ation	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,Year)	1 Yes 2 No								
Division of Vital Records, spiral a Astending Physician: The law requirents after death meral Birector. After this certificate has been sfilled in by the funeral director, page 2 should Certification: To Be Completee	3 Suicide 6 Could not be determined (Be. Place of Injury - At home, farm, stre	et, factory, office building, etc.	28f. Location (Street a or Town, State)	and Number or Rural R	oute Number, City					
Division of Vital I To the Bospital of Attending Physician: within 24 hours after death To the Funeral Birector: After this certific completely filled in by the funeral director. Medical Certification: To Be (the best of my knowledge, death occu e basis of examination and/or investigal nanner stated.				use(s)					
F 3 F 8	11 61		29c. License number O.C.M.E.		Date signed (Month, Date 1, 2006	Day, Year)					
	30 Name and address of person who comple		0.0.0								
15	Ling Li, MD Assistant Medica		et, Baltimore, MD 21201								
State Registra	8110 0 9 2005	32. registral s Signature	ule								

06-05546

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Lietera Omar 1- For State Certificate of Death Reg. No Registrar 2. Date of Death ecedent's Name (First, Middle,Last) Physician/ Year Month Day July 29, 2006 1510 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Murray Hill Road @ Guilford Road Columbia Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of Funeral Months Days Hours Min Director 218-29-4346 Country) MD M 2 V F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h Counts ž 1 Yes 2 No nLumBiA 28a-f show HOWAR Director 10g. Citizen of What Country 23a or 28a-21046 Funeral 12. Was Decedent Ever Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. Never Married 2 Married Yes Divorced If Yes, Give Year Yes 2 No specify: Widowed ģ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit Pages I and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "u
injury or other traumatic event. the Medical E Baltimore, MD 21215-0036 Studen 18.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) æ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Tower 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Toy Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 Other Specify Signature of Funetal Service Licenses 6.1 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Part I. Enter the disease, failure. List only one caus **Physician** Between Onset and /Medical Death Cardiac arrhythmia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical X UNPENDED physician the burial -AMENDED item#23a,27,perME,g860, 10/2/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery . Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autoosy prior to completion of cause of After this certificate has performed' death? page 2 ✓ Yes 2 No 1 V Yes 25. Was case referred to medical 26 Place of Death (Check only one) Be Other₄ examiner? Inpatient ldoa Nursing Home 5 Residence 6 ✔ Other: Scene 2 ER/Outpatient 3 1 V Yes 2 No ဥ 28c. Injury at Work? 28a. Date of Injury (Month, Day,Year 28d Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural 5 Pending 1 Yes 2 No To the Funeral Director: Accident Investigation l in by t 2Be. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 29c. License numbe July 30, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD.

31. Date filed (Month, Day, Year) State

AUG 0 distrar's Signature

ORIGINAL

			1- State Amend item#4a, pe	State of Ma enMD, 10e,18	ryland / Depa , 19a-b, per l	artment	t of H	ealth a	nd M	ental Hygi	ene2 ()	06	24392
			Decedent's Name (First, Middle, Last)							2. Date of Death		V	3. Time of Death
	Physici		Michael Francis 0	'Braden						Month July 21	Day 2006	Year	11:29 AMM
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. Cily, 1	Town, or	Location o	f Death		4c. County		
			343 Firelight Lan			Ba1	timo	re			Balt		
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Birth (Month, Day, Sept 23	Year)	9. Birthp	place (State or Foreign
	Director		215-64-3016 X	M 2□F	53 Yrs.					Sept 23	, 1952	Mar	yland
	pu a		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation							10d. Inside City Limits
	sho	5				imore							1 ☐ Yes 2 ☑ No
	28a-f	ect	MD Baltimor	е	Dall	10f. Zip				10	g. Citizen of V	/hat Cou	
	be filed within 72 hours after death with the Maryland that Hygiene. Indi Hygiene and the first file of 28 or 28 or 40	Funeral Director	343 Firelight Lan	ie #G		TOT. EID		207			-	JSA	
	ns 23	erai		12. Was Decedent E	ver in U.S. 13.	Was Deced	ient of Hi	ispanic Orig	gin? (Spe	ocify Yes or No-			can Indian,
.	frer deal	F	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give	0	If Yes, spec	ify Cuba	n, Mexican	, Puerto	Rican, etc.)	Blac	k, White,	etc.
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ם	be fill	Be	17. Father's Name (First, Middle, Last)							(First, Middle M			
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altimore,	0 0 = 5		1 Burial 2 Cremation 3 R	lemoval from State	cemetery, cre.	matory or of	ther plac	e)					•
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			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused		lltimo					st.		Approximate
ı			shock, of heart failure. List only or Immediate Cause (Final			00	011	1100	011			21	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or is a	STAGE consequence of):	C 30	100	my c	711	CANCE	ek u	1112	
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	uted d ansit	Examiner	Cause (Disease or injury that initiated events	Hupe	rtens	101	D						YRS
ó	exec an an riaf-tr		resulting in death) Last	Due o or as a	consequence of):	1		1		2/1.	/		1.12
760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	cal		Lept	hemis	oleg	ca	from	n 2	Aron	حد		4R
68	tifica ng ph as th	Medi	IC FCW I F					0			1		
Вох	th cer tendir r use	an/N	23b. was decedent pregnant	3c. If yes, outcome of 1 ☐ Live birth		∃Ectopic pr	egnancy					e of deliv	,
	ne dea the att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 1 9☐ Unknown		Other (sp					Moi	านา	Day Year
P.0	that the death cer ed by the attendir detached for use	Physician/Med	9 🗆 Unknown					1.0		OR- Didash			ha a super of death 0
	res tha signed be det	by	Part II. Other significant conditions cor	ntributing to death bu	t not resulting in the C	inderlying ca	ause giv	en in Part i	•		acco use conti s 2 □ No	3 ⊟ Prot	he cause of death?
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	-	1	30. Name and addres are rson who co	ompleted cause of de	eath (flem 23a) Type	phit)		1	1.1	7.	1, 1	n. 1	2006
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0.		ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Post!	0		-		•		
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		for State	State of Marylan			Mental Hygier	ne2006	24394
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		5. Social Security Number 6. Sec	7. Age (In yrs.	last birthday) If Under	er 1 Year If Under 24 Hrs	8. Date of Birth	Vlant 46	
Funeral Director		238-48-6134	(M 20 F 72	Yrs. Months	Days Hours Min.	12-25-1	133	NC NC
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ler de	in e	11. Marital Status 1 □ Never Married ★ Married	12. Was Decedent Ever in U Armed Forces? 1 XYes 2 ☐ No	.S. 13. Was Dece	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puer	респу Yes or No- to Rican, etc.)	14. Race - Amer Black, White	etc.
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Man y Idilio A. I.A. 12 should be filed within h and Mental Hygiene. 7 le marked other than trsumatic event, tra M		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing Address	s (Street and Number or Ri	ural Route Number, Cit	y or Town, State, Zi	Code)
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Bath contact attend for us	clan/	in the past 12 months?	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	ıl death 3 □Ectopic ı			23d. Date of deliver Month	rery Day Year
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Sy T es the gned i	by P	Part II. Other significant conditions co	. A		cause given in Part I.			the cause of death?
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e law in the bound in 2 sh	Completed					24a. Was an autopsy performed	24b. Were aut prior to co death?	opsy findings available ompletion of cause of
ian: Th rifficate rtifficate	e Co	25. Was case referred to medical			00 81	1 □ Yes 2Æ	No 1 ☐ Yes	2□ No
ysicia s certi directo	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 0	Othor	ath <i>(Check only one)</i> Home 5☐ Residence	6 ∏Other (Spec	(fv)
eg Phy ge Phy Jerahia		27. Manner of Death	28a. Date of Injury (Month, Day Year)		28c. fnjury at Work?	28d. Describe how in		
eath. or: Af	catic	1 (2Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		М	1 ☐ Yes 2 ☐ No			
LIVISION I or Attending after death. I Director: Afte	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special		ry, office	28f. Location (Street City or Town, St		ral Route Number,
To the Hospital or Attending Physician: The law requires then the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detected for use as	edicai C	29a. Certifier (Check only one) 1. Certifying Phy 2 Medical Exam	sician: To the best of my knoiner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and place in, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	مععم	25	9c. License number		Date signed (Month	Day, Year)
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		30. Name and address of person who c			.4.0	11 - 2 000		
St	ate	31. Date fifed (Month, Day, Year)	22. Registrar's Sign	ature 201	ia nasa, s	wh 250	10(US0N	1712/286
Regist		SUNIZA BLOQUE 31. Date filed (Month, Day, Year) AUG 0 3 2008	Server Si	Jag January .				
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State of Maryland / Department of Health and Mental Hygiene 115

			1 - For State Registrar	olato of Marylan	ila / L	Certii	ficate of L			Reg. N	o.	24000
b	Physici	30	1. Decedent's Name (First, Middle, La						2. Date of De Month	Π.	ay Year	3. Time of Death
	Physici /Medic		Alvin Thoma						AUGUS		01 200	,-
	Examin	er	4a. Facility Name (If not institution, gir SAINT AGNES		_	1	-	NORE		40	c. County of Dea	atn
- Signa	Funeral Director		5. Social Security Number 6.	Sex 7. Age (In yrs	. last birt	hday) I	f Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 11/20/	th ay, Year 1 936	9. Bi	rthplace (State or Foreign ountry)
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	e Maryla la-f shov	ctor	Maryland Maryland		ltimo							1 Styles 2 No
	th with th	Funeral Director	10e. Street and Number 1000 Arion Park #	! 93			10f. Zip Code 21229			10g. C	itizen of What C	ountry?
2-003p	d within 72 hours after death with the Maryland jene. r than "natural", or Itema 23a or 28a-f show the Modical Examinational be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Vidowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1∑Yes 2 No If Yes, Give Year or Dates:	U.S.	1	s Decedent of Hi es, specify Cubai Yes 2 1	spanic Origin? (S) n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.))-	14. Race - Am Black, Whi Specify:	
2	72 ho	eted	15. Decedent's E (Specify only highest gi		16a.	(Give kin	it's Usual Occupa id of work done o	luring most of wor	king	16b. l	Kind of Business	s/Industry
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ם ס	be filed ital Hygi of other	a	17. Father's Name (First, Middle, Las	t)				18. Mother's Nan	ne (First, Middle	, Maide	n Surname)	
ylar	Menta Menta arked	To B	Elmer Phelps					Loretta				
Mar,	s 1 and 2 should f Health and Mer flem 27 is marke other traumatic		19a. Informant's Name/Relationship Colleen Day, Daug					e Ct., H				Zip Code)
altimore	it. Pages 1 artiment of He riant: If Item		20a. Method of Disposition 1 Starial 2 □ Cremation 3 (4 □ Donation 5 □ Other (Spec	Removal Irom State	cemeter	y, cremat	on (Name of fory or other place Memorial F	e) Parok 8/5/20	Date 106		cridge,	
Ball	permit. Pages Department of Important: If I any injury or once		21. Signature of Funeral Service Lice	M01234		Gar	ame and Addres Cy L. Ka 50 Washi	uf Facility ufman Fu ngton Bl	neral H	ome krid	at MMP,	INC. 21075
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68/60,	tificate be executed g physicien and as the burial-transit	Medicai Ex	resulting in death) Last	Due to (or as a conse	OCCUPATION OF	M).			710 N			7 days 7 days
O. Box 6	death cer e attendir id for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fer 4 □ Pregnant at time of 9 □ Unknown	tal death		ctopic pregnancy other (specify)				23d. Date of de Month	Blivery Day Year
rds, P	w requires that the been signed by th should be detache	ρλ	Part II. Other significant conditions	contributing to death but not re	esulting in	the unde	erlying cause give	en in Part I.		tobacco Yes 2		to the cause of death? Probably 4 Unknown
II Hecords,	The law ate has b page 2 s	Completed							24a. Was auto perfo 1 Yes		prior to death?	
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital: N.			3 DOA Othe	26. Place of Dea				
on of	ing Phy I. After this funeral d	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		ime of	28c. Injury Work	4 🗀 Nursing n	ome 5 ☐ Resi 28d. Describe		6 ☐Other (Speury occurred	ecify)
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	To the within 2 To the complete	M	29b. Signature and title or certified	1 auns	, 19	I.P	29c. License	18611 ACTIN		29d. D	GUSTOI	St 2006
-	6		30. Name and address of person who HAGDALENA	completed cause of death (Ite	em 23a) (Type, Pri	(nt) 900 _B	ACATO	N AVE	M	10 21	229
A STATE OF	- Sta Registi		31. Date liled (Month, Au God) 3	2006 32. Registrar's Sign	nature	Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan	marke			/		

			-	yland / De	partmer	it of Health and e of Death	Mental Hygie		24395
Physici /Medi	cal	Decedent's Name (First, Middle, Last) David Lee Perryman			dh Cin	Town, or Location of Deat	2. Date of Death Month August	Day Year 2, 200	3. Time of Death 9515 am
Examir	ıer	4a. Facility Name (If not institution, give st Union Memorial Hos				Baltimore			N/A
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Maryland I-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	1	Oc. City, Town or		timore			10d. Inside City Limits XX Yes 2 □ No
with the	l Direc	10e. Street and Number 1436 W. 37th Stree	t		10f. Zi	Code 21211	10g	. Citizen of What C	country? USA
ges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If Item 27 is marked other then "naturel", or Items 23a or 28s-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed Maried	2. Was Decedent Ev Armed Forces? 1 □ Yes ŽŽNo If Yes, Give Year or Dates:	er in U.S.	3. Was Dece If Yes, spe 1 \(\text{Yes}	dent of Hispanic Origin? (S cify Cuban, Mexican, Puer XX No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	
in 72 ho	Completed	15. Decedent's Educa (Specify only highest grade	completed)	(Gi	cedent's Usu ve kind of wo	al Occupation ork done during most of wo se retired)	rking 16	b. Kind of Business	s/Industry
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should be find my Mental H marked of umatic even	To Be	Michael Perryman					hy Wright	den Sumame)	
and 2 sho ealth and In 27 is mu		19a. Informant's Name/Relationship (Type Dorothy P. Fink	e, Print) Siste		_	(Street and Number or Ri ht Road Po	ura <i>l Route Number, C</i> rtsmouth,	-	
parmit. Pages 1 and 2 Department of Health a Important: If Item 27 is any njury or other tra		20a. Method of Disposition 1 ☆ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. Place of Dis cemetery, c	rematory or	orial Pk 8/5		c. Location - City o	r Town, State , Maryland
permit. Pag Depertment Important: any njury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	-			nd Address of Facility -Henss-Seitz alls Road B	·		
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be executed icien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):					
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uires that the devision of the a	by Phy	Part II. Other significant conditions cont		not resulting in the	underlying	cause given in Part I.	23e. Did tobac	co use contribute	to the cause of death?
w require been sig					 				robably 4 Dunknown
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 s	e Completed	25. Was case referred to medical				OS Plane of Pa	24a. Was an autopsy performed 1 Yes 2 & ath (Check only one)	d2 prior to death?	utopsy findings available completion of cause of s 2 No
Physicia this cert al direct	To B	examiner? 1 Yes 2 No	spital:			OA Other: 4 Nursing H	tome 5 Residenc		ecify)
auth. or: After he funer	atlon:	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day)	(ear) 28b. Time	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
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Hospits 24 hours Funera etely fille	Medical (29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of er: On the basis of e and manner state	xamination and/or	ath occurred investigation	at the time, date and place, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner a and place, and du	is stated. le to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier) 4		29	c. License number	24	Date signed (Mon	
h		30. Name and address of person who com	M, N	th (Item 23a) (Typ	e, Print)	124369	46 Au	gust 2	2006 MD
Sta	ate.	Gere D. Felto 31. Date filed (Month, Day, Year)	S MT	s Signature	NIOV	Memor	ial Hos	pital,	MD
Regist		ALIC 0 3 2006		. B. A	souls?	-			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** REICH 9:046 BETH FRANCINE TULY 31 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 7. Age (In yrs. last birthday)

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One of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 👿 F MD 215-60-6332 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or iteme 23a or 28e-f ehow tre Medical Examiner must be notified at 1 ☐ Yes 2 X No Funeral Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21228 550 REST AVENUE filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Kn No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) OCCUPATIONAL THERAPIST OCCUPATIONAL THERAPY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Ie marked oth any filury or other traumatic event any injury or other traumatic event anse. Be BOROFSKY **ARBESMAN** EVELYN BERNARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip CodeAPT 1 19a. Informant's Name/Relationship (Type, Print) 3203 OLD POST DRIVE - BALTIMORE, MD 21208 BERNARD ARBESMAN / FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/02/2006 RADOMER VEREIN CEM. ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COMPLETE HEART BLOCK **Physician** 1 DAY /Medical Due to (or as a consequence of): Examiner CASTLEMAN'S DISEASE YEAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Box 68760, \(\frac{1}{2} \) that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical as 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Yes 2 XNo 1 TYes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1XInpatient Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 No ို 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending death. 1 Tes 2 No investigation Director: 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide after within 24 hours a To the Funerel (🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) TIMOTHY F BURNS MO / PHO RES-000 2006 JULY 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMIRE, MARYLAND 31331 600 North Wolfe Street, TIMOTHY F BURNS 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 3 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** JULY 22 2006 2:30 A JOSSALYN SHAE SHINAULT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (Standard) 9. Birthplace (Standard) 9. Birthplace (Standard) 4. July 22, 2006 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Min. 37 1 □ M 2 🗓 F Davs Hours Months Yrs Director NONE Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-1 show **Worle** 1 ☐ Yes 2 X No Quantico Virginia Prince William Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Heatth and Mental Hygiene. Int: If item 27 is marked other then "neturel", or items 23a or 3 Examiner must be or U.S.A. 22134 13116 Adams Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White If Yes Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) N/An 17 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amanda Candice Church Shinault Billy James Shinault ဥ 19a. Informant's Name/Relationship (Type, Print) (Parents) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
eny injury or other trau 13116 Adams St., Quantico, VA 22134 Billy & Amanda Shinault 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Roselawn Mem. Gardens 7/27/06 Princeton, WV 4 Onation 5 Other (Specify) 21. Signature of Funeral Service Licensee Seaver Funeral Home umen 1507 N. Walker St., Princeton, WV 24740 onno 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** EXTREME PREMATURITY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician ician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐XNo P.O. the detached Physi 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 y Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 XNatural 2 Accident after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after de Funeral Direct filled in by 4 🗌 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. icai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2

Registrar

31. Date filed (Month, Day, Year) AUG 0 3 2006

29b. Signature and title of certifier

KATHY L. KYSER

USN LCDR MC 32. Registrar's Signature Market and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

29c. License number

0101238735 (VA)

29d. Date signed (Month, Day, Year)

24

July

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

State of Maryland / Department of Health and Mental Hygiene [] [Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** RUBY VIRGINIA August 2006 10:10p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health Care of Laurel Laurel Prince George's 8. Date of Birth (Month, Day, Year)
Apr. 3, 1914 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 219-16-8194 92 Virginia Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location ehow. 10d. Inside City Limits Item 27 is marked other then "netural", or items 23a or 28a-f eho: other traumatic event, the Mudical Examinar must be nutified at 1 ☐ Yes 2 ☐ No Directo MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6704 Brooklyn Bridge Road 20707 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ☐Yes 2 X No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: ģ Specify. 3 X Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify onfy highest grade completed) 16b. Kind of Business/Industry 12 should be filed within in and Mental Hygiene.
7 Is marked other then "I Electronics Elementary/Secondary (0-12) College (1-4or 5+) Grade 5 Electrician Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Cleveland Ford Addie Shipe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ent: If Item 27 le Tracy K. Smith / grandson 20553 Deerwatch Place Ashburn, Virginia 20147 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XX urial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any Injury or one. Ivy Hill Cemetery 8/5/2006 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home, 21. Signature of Funeral Service Licenses me, P.A. Laurel, Maryland edia / M00773 delit 313 Talbott Avenue 20707 23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration Pneumonia l Day disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Alzhiemer's Disease 3 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be deteched t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes XXNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ № 0 24a. Was an has autopsy performed? Yes 2XXVo 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 X Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 💢 o 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: To the Hospitel or Attending within 24 hours after death.
To the Funerel Director: After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation nerel Director: , filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 24721 August 2, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sadiq 14333 Laurel Bowie Road Suite 208 Laurel, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 24400 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** MIT SAMPSON 31 2006 3:00 PM JULY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner FUTURECARE-HOMEWOOD BALTIMORE CITY N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2 ☐ F Yrs. 17/1932 VIRĞINIA Director 226-36-6175 74 Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or iteme 23a or 28a-f ehow the Medical Era Liner must be notified at BALTIMORE CITY MD N/A 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 USA 1407 OLIVE STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1X Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify WHITE ል 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) LABORER Elementary/Secondary (0-12) LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth eny lightly or other traumatic event space. Be UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 N.CALVERT STREET, BALTIMORE, MD 21202 ARTIE SHAW / LEGAL GAURDIAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/3/06 CATONSVILLE, MD METRO CREMATORY 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature properal Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD per the disease, or complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cuchomy pesty **Physician** untercur /Medical Examiner Unler Obstroctiv Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Marce Examiner Due to (or as a consequence of): certificate be executed physicien and s the burial-transit and Due to (or as a consequence of): Box 68760, Physician/Medicai the attending property of the design of the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown Q. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Donknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy 1 Yes 2 No 1 Yes Division of Vital Physician: To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to dical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 € ဥ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determin 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after d To the Funerel Direct 4 Homicide 29a Certifier 1♥ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examinar: On the pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0054056 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rayal Are Bet Saluji 1600 Sut 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 3 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene? [] [] [24401 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** GERTRUDE 647 pmM A 06 SEAGER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Brightwood Genesis Eldercare Brooklandville Baltimore County 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth June 26, 1910 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1□M 2ĂF 96 Yrs 234-48-4331 Virginia Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State or Items 23a or 28a-f show the Medical Examiner must be notified at Baltimore County 1 Yes 2 No Maryland Lutherville Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 8413 Macauley Court 21093 United States death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2½ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 → Widowed 4 □ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Roofing and Sheet Metal Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper 10 N/A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked oth any lighty or other traumatic event once. Miller M. Matthews Margaret Yost 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Georgann S. Caldwell (dgtr) 8413 Macauley Court, Lutherville, Maryland, 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel Aug. 3,2006 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Peaceful Alternatives Funeral & Cremation Ctr, P.A. 2325 York Road Timonium Maryland, 21093 0 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TOTHRIVE Physician FAILURE MONTHS /Medical Due to (or as a consequence of): **Examiner** MONTH ADVANCED DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physician Completed by Physician/Medical be detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 2 No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1/6 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Division Natural 5 Pending investigation after death. 1 Yes 2 No 2 Accident the 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) NQ U 4 Thomicide within 24 hours a To the Funeral L completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053150 8.2.06 Styphe MD 30. Name and indress of person who completed cause of death (Item 23a) (Type, Print) SANTIAGO ROAD GUPTA 9650 ShALLINNHALA 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 0 3 2006 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year William Brush **Physician** Shippen Sr. 9:10 am 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5. Social Security Number 6. Sex Baltimore Cit Baltimor If Under 1 Year Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1☐M 2☐F Director 579-10-5422 88 Aug 13 1917 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 2 should be filed within 72 most-i and Mentel Hygiene. 7 is marked other than "netural", or teme 23a or 28a-f show 7 is marked other than "netural", or teme 23a or 28a-f show Md Carroll 11 Yes 2 □ No Sykesville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue 21784 USA Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give 21 Year or Dates: Specify: white 3 X Widowed 4 ☐ Divorced

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

P.O. Box 169, Mt. Airy, MD 21771

thermal engineer

All County Cremation 8-3-06

20b. Place of Disposition (Name of cemetery, crematory or other place)

16b. Kind of Business/Industry

20c. Location - City or Town, State

Sykesville, MD

engineering

18. Mother's Name (First, Middle, Maiden Surname)

22. Name and Address of Facility Haight Funeral Home & Chapel

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 195, Sykesville, Md 21784

Florence Hawley Brush

permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Important: If item 27 is marked oth any injury or other traumatic event size. **Physician** /Medical

Be

Maryland 21215-0036

Baltimore,

Sillian

Examiner

Physician/Medical Examine burial-tran ettending physicien for use as the burial þ ils certificate has been signi director, pege 2 should be Be Completed Certification; To funeral death. within 24 hours efter death

To the Funerel Director:
completely filled in by the

The law requires that the death certificate be executed

Hospital or Attending Physicien:

the

Division of Vital Records, P.O. Box 68760,

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) wace re Due to (or as a consequence of): Security list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1□ inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ Ne 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation **√** Natural 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide nd Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only 29c. License number 29b. Signature, and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

Lloyd Parker Shippen

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

Robert S. Shippen (son)

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

Dauge Haight Herbert



ORIGINAL

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			Registrar			ertifica	te of D	eatn		g. No.	
Ph	ysicia	ın	Decedent's Name (First, Middle, Last)						2. Date of Death Month	Day Y	3. Time of Death
	Medic		Alfred Wayne Simpl			1 5			July 30,		8:05 PM M
Ex	amine	er	4a. Facility Name (If not institution, give s					ocation of Death		4c. County of	Death
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rylan	3		10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limits
e Ma	Illies	cto	MD		Balt	imore					1√Yes 2□No
ith th	20.00	Director	10e. Street and Number			10f. Z	p Code	01001	10	g. Citizen of Wha	
15-0036 T2 hours after death with the Maryland "natural", or Items 23a or 286-1 show	MEL		828 Eutaw Stree					21201			JSA
er de	Der	Funeral		12. Was Decedent Armed Forces?	Ever in U.S.	I3. Was Dece If Yes, sp	edent of Hisp ecify Cuban,	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
36 rs aft	Xam	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:	NO	1 🗆 Yes	2X No .	Specify:		Specify:	white
2 hou	EalE	pel	15. Decedent's Educ	ation	16a. De	ecedent's Us	ual Occupation	on		6b. Kind of Busin	ess/Industry
:1215-0036 within 72 hours after and matural; or ite	MEG	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	5+) (G	ive kind of w e. DO NOT	ork done dur. use retired)	ing most of work	ring		
21.2 d wit	2	Completed	10	0		borer			1	ome imp	rovement
nd Se file Balty	vent	Be (17. Father's Name (First, Middle, Last)				18	B. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	
yla Wenidil	atic	2	Maurice A. Simpki						ee Turpir		
Maryland 21215-0036 d 2 should be filed within 72 hours all th and Mental Hyllene. This marked other than "natural", or	reum	М	19a. Informant's Name/Relationship (Type Roger Lee Simpki			•	•		al Route Number,		
e, land	or other treumatic event, the Madical Examinar must be notified at		20a. Method of Disposition	115/ 010 6116	20b. Place of Di				oklyn Par	oc. Location - Cit	
Baltimore	0 10 /		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery,	crematory or	other place)				y 0. 10mm, 0.0.0
Itin	njur)		4 □ Donation 5 ☑ Other (Specify)			-22 Name a	ad Address	of Famility a	655 T.T. T	0.1+imor	o Street
Baltimore, Maryland 21215 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if them 27 is marked other than "na	Suc.		21. Signature of Funeral Service License ROTIA 1 d S	ady, 7				D 2120	655 W. E	altimor	e bilect
5			23a. Part Enter the dispase, or complic	cations that caused	the death. Do not					st,	Approximate
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/Med	100		disease or condition resulting in death)	Due to (or as	a consequence of):	ano	ll car	cei			months
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	use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	of pregnancy					23d. Date o	f delivery
₩ eath	I for t	clar	in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 ☐ Fetal death t time of death	3 ☐ Ectopic p 5 ☐ Other (s				Month	Day Year
P.O. that the ed by the	achec	hys	9 Unknown	9□ Unknown							
S, P		by P	Part II. Other significant conditions con	tributing to death b	ut not resulting in th	e underlying	cause given	in Part I.	23e. Did toba	cco use contribu	te to the cause of death?
Cords,	should b								1 ☐ Yes	2□No 3[Probably 4 Unknown
(() 0 3 0		Completed							24a. Was an autopsy	24b. Wer	e autopsy findings available r to completion of cause of
Vital Reci	page	Con							performe	ed? dear	
Vital Vital Carifice	octor.	Be (25. Was case referred to medical examiner?				-		h (Check only one)		
of Vita Physicien:	al dire	P,	1 62 2 140	ospital: 1 Inpatie				4 Nuising no			Specify) Hospice
After After	funer	i o	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry Yea <i>r)</i> 28b. Tim y Yea <i>r)</i> Inju	e of ry M	28c. Injury at Work?	s 2 🗆 No	28d. Describe how	injury occurred	
Vision Attending	the the	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of Ini	ury - At home, farm				28f Location (Stre	et and Number o	or Rural Route Number,
Division Lor Attending after death. Director: Afte	i D	Certification;	4 Homicide determined	building, et	c. (Specify)	, street, racio	ry, onice		City or Town,		, rida riogio riginos,
ospita hours	y fillec		29a. Certifying Phys	sician: To the best	of my knowledge, d	eath occurre	d at the time,	date and place,	and due to the cau	se(s) and manne	er as stated.
Division Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	completely filled in by the funeral director, page 2	ledical	(Check only 2 Medical Examinons)	and manner st	ated.						
Township	Loo	Σ	29b. Signature and title of certifier			1	e. License n				fonth, Day, Year)
			2 Per Mis				72	4170		July 3	1,2006
			30. Name and address of person who co	mpleted cause of c	leath (Item 23a) (Ty	pe, Print)	FILE	1 S.	Rall.	~ MI	1,2006
States States	∗ Sta	e	31. Date filed (Month, Day, Year)	32/Regis	ar's Signature			V* / I	1200011120	7-1-1	
Re	egistra		AUG 0 3 2008		JA A	review					

State of Maryland / Department of Health and Mental Hygiene 0 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Thompson 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner BAltimore MARyland Medical Center NIA If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□F 220-73-7496 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1XYes 2 □ No BALTIMORE by Funeral Director 10e. Street and Number 10g. Citizen of What Country? U.SA GROVE death Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 □ Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use getired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Pages 1 and 2 should be THOMPSON. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Depertment of Health ar important: If item 27 is eny injury or other trauonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATOR CATONSVILLE MO 21. Signature of peral Service Licensee 22. Name and Address of Facility FUNERAL HOME 4600 LIBERTY HOTS ler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between shock, or heart failu Immediate Cause (Final disease or condition resulting in death) Onset and Death Myocarditis **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner physician and the burial-transit Hospital or Attending Physicien: The law requires that the daath certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 3 ☐ Probably 4 X Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No has this cartificate Yes Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 Appatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury death. 1 Yes 2 No investigation f Director: / 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours after To the Funeret Dira 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) To the 29b. Signatyne and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060702 susanna cause of death (Item 23a) (Type, Print) Baltimore Susanna Scafidi 22 Greene St Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 3 2006 Registrar

			1 - State of Marylan Registrar		irtment of Heal tificate of Dea			ne_2 0	06	24405
П	Physici	an	1. Decedent's Name (First, Middle, Last)			2.	Date of Death Month	Day	Year	3. Time of Death
	/Medic		Charles Raymond Vogelsang				July 31	, 200		8:00 A ^M
A.	Examir Funeral	er	4a. Facility Name (If not institution, give street and number) 670 Wise Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. 1 M № 2 □ F	"		Under 24 Hrs. 8.	Date of Birth (Month, Day, Yo	Anne	Arui	ace (State or Foreign
	Director		218-28-1976 75 Usual Residence of Decedent	Yrs.			3/04/1	931		MD
	yland Now			y, Town or Lo	cation				10	d. Inside City Limits
	e Mar	ctor	MD Anne Arundel Pas	adena						1 ☐ Yes 2 🗷 No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of W	hat Counti	ry?
	s 23s	rai	670 Wise Avenue	2 101	21122			J.S.A.		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other then "natural", or items 23s or 28e-f ehow other traumatic event, the Medical Examinal must be notified at	by Funeral	If Yes, Give	21-	Vas Decedent of Hispan Yes, specify Cuban, Me Yes 2X No Sp	nic Origin? (Specif exican, Puerto Ric pecify:	y Yes or No- an, etc.)		- America k, White, et	tc.
5-0036	stural	ed b	15. Decedent's Education	16a. Deced	ent's Usual Occupation		16	b. Kind of Bu		
21215	ithin 72	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. D	kind of work done during OO NOT use retired)	g most of working				•
22	filed w Hygier other ti	CO	12 17. Father's Name (First, Middle, Last)	Steam	m Fitter	Mother's Name (F	irst Middle Mar			c Supply
Maryland	d be f	To Be	Charles Albert Vogelsang			Anna He	_	oon oomana	*/	
3	should be and Mental marked umatic ev	Ĕ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and N			ity or Town, s	State, Zip (Code)
	and 2 ealth a n 27 is		Anna Vogelsang / Wife	670	Wise Aven	ue, Pas	adena,	MD 2	21122	2
ore	of He of He of Itam of Other		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State	tace of Dispos emetery, crem	sition (Name of natory or other place)	Date	200	c. Location -	City or Tow	m, State
altimore,	Pages Iment of I tent: If Its jury or o		4 Donation 5 Other (Specify) MD		rans Cem	the second secon	1/06 Cr			
Ba	permit. Pages Department of Importent: If it eny injury or o		21. Signature of Figneral Service Cicegsee		Name and Address of 69 Rivier					
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	n. Do not ente	er the mode of dying, suc	ch as cardiac or re	espiratory arrest			Approximate Interval Between
4	Physician		tmmediate Cause (Final disease or condition resulting in death)	1 call	come	g l	ung			Onset and Death
	/Medical Examiner		Due to (or as a consequence	ùence of):		1	0			
ļ		ner	flany, leading to immediate cause. Enter Underlying	uence of):						
$\sqrt{}$	acuted ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecu-							
8760,	ificate be executed g physicien and as the burial-transit	al Ex	Due to (or as a consequ	Jence of):						
687	ficate physics the	edical	d							
P.O. Box	death cert e attending d for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)	·		23d. Date Mon	of delivery	/ Day Year
	quires that n signed b ıld be deta	by	Part II. Other significant conditions contributing to death but not rest	ulting in the un	derlying cause given in	Part I.				cause of death?
Division of Vital Records,	hysician: The law requires that the his certificete has been signed by the director, page 2 should be detache	Completed					24a. Was an autopsy performed	1? pi	nor to comp eath?	sy findings available pletion of cause of
ā	ian: intifice ctor, p	Be C	25. Was case referred to medical examiner?		26.	Place of Death (C				
<u>></u>	hysic his ce	101	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient		☐ Nursing Home	5 Randence	e 6 □Othe	r (Specify)	
Ono	Attending Ph or death. ector: After th by the funeral	tion:	27. Manner of Death INTERNATION STATE 28a. Date of Injury (Month, Day Year) 2 ☐ Accident investigation	28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes		. Describe how	njury occurre	od	
Divis		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office	28f.	Location (Stree City or Town, S	t and Numbe tate)	r or Rural i	Route Number,
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	Medical C	29a. Certifier (Check only one) Check only one) Check only and manner stated.	wledge, death tion and/or inv	occurred at the time, da estigation, in my opinion	ate and place, and n, death occurred	due to the caus at the time, date	e(s) and mar and place, a	ner as stat	ted. he cause(s)
	vithin o the	Me	29b. Signature and title of certifier		29c. License num	nber	29d.	Date signed	(Month, Di	ay. Year)
	. , , , 0				91	18500	P	1-	1-6	6
	641		30. Name and address of person who completed cause of death (Item	1 23a) (Type, F	30					
)		Charles Wu MA 1600 S. Cro	in Hw	y Ste. 106,	Glen B	Juniz,	WP 3	1061	
7	Sta Registr		Charles Wu M.N. 1600 S. Cro 31. Date filed (Month, Day, Year) ALIC 0.3 2006	K A	race					

				State of Maryland				Mental Hy	giene	24405
	Del		1 - State Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of	Death	2. Date of De	Reg. No.	3. Time of Death
	Physici		Virginia Marie	Voluse				Month	31 2001	
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, o	or Location of Deat		4c. County of Dea	J
			BACTIMOTER WARHINGT	ON MEDICAL	Cent	EK C	iten Bi		ANNE 1	HRUNDEL
	Funeral Director		210-20-9752	7. Age (In yrs. Ia M 2 X F		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Da 11/08	9. Bir 3/1926	thplace (State or Foreign ountry) NY
	and wc		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary in the	to	MD Anne Ar	undel Pa	sader	na				1 ☐ Yes 2 🛣 No
	or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	23a c	ral	3 Carvel Court			2112	2		U.S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "naturel", or Items 23a or 28a-f ehow apply fourly or other traumatic event. The Medical Examinar must be multiled at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	 Was Decedent Ever in U.S Armed Forces? Yes Ki Yes, Give Year or Dates: 	li li	Vas Decedent of H Yes, specify Cub ☐ Yes 2 No	Hispanic Origin? (S an, Mexican, Puerl Specify:	specify Yes or No to Rican, etc.)	Black, Whi	
21215-0036	2 hou	Completed by	15. Decedent's Educ	ation	16a. Deced	lent's Usual Occup	pation	dina	16b. Kind of Business	/Industry
215	thin 7	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retire		rking		
	led wi lygien her th nt. In		12		Clair	ns Proc		(Circh Middle	Insuranc	e
and	t be fi	Be	17. Father's Name (First, Middle, Last)	+ o w a				Ellen 2	Maiden Sumame)	
Maryland	shouk nd Me mark matte	유	Paul Chester Wa 19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street			er, City or Town, State,	Zip Code)
	nd 2 :		William Voluse	/ Son	420 (Century	Vista	Drive,	Arnold,	MD 21012
ore,	of Hei		20a. Method of Disposition 1 ☐ Burial 2 🖫 Cremation 3 ☐ Re	20b. PI	ace of Dispos	sition (Name of natory or other pla	ce)	Date	20c. Location - City or	Town, State
Ē	Page ment ant: fl ury o		4 Donation 5 Other (Specify)	Bay			ory 08/		Baltimor	
Baltimore,	permit. Depart Import eny in		21. Signature of Emeral Solvice License						ce Funera sadena, M	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cause on each line.			-		rrest,	Approximate Interval Between Onset and Death
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		e	if any, leading to immediate	Oye to (or as a consequ	ence of):	भागा ग	m acre	p#		
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ν O	e exectan an an arrial-tr	Exe	resulting in death) Last	Due to (or as a consequ	ence of):					
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9	ding p	/Med	IF FEMALE:	c. If yes, outcome of pregnar	nev				00.4.0.4.4.4	P
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rds, P	requires that been signed b should be deta	Ď	Part II. Other significant conditions conf	ributing to death but not resu	ilting in the ur	nderlying cause gr	ven in Part I.		obacco use contribute t Yes 2 □ No 3 □ P	o the cause of death? robably 4 Sunknown
l Records,	The lay ate has page 2	Completed						24a. Was autop perfo 1 Yes	prior to death?	utopsy findings available completion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		100		ath (Check only o	ne)	
of	\$. <u>v</u> ₽	. To	1 Tyes 2 No	1 Vinpatient 2 ☐ t 28a. Date of Injury	ER/Outpatien 28b. Time of	t 3□ DOA 28c. Inju			dence 6 Other (Spenow injury occurred	icify)
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	e Hospital 124 hours a Euneral letely filled	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the treestigation, in my	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature an other of certifier		1.1	29c. Licen.	se number		29d. Date signed (Mon	th, Day, Year)
)			12 She		YVI	- 12	45149		fully 31	1006
	le		30. Name and address of person who con	1301 Hosp	tal !	Print)	Glen F	zwine	mp 2	1061
	Sta Registi		31. Date filed (Month, Day, Year) 3 20	32. Hogistrar's Signat	J. A	pare				

Voluse, Virginia

			1 - For State Registrar	State of M	larylanc			nt of H				giene Reg. No.	71111	6	244	07
	Physici		1. Decedent's Name (First, Middle, La	,	Vilson	W	elli	ngs			2. Date of De Month July	Day		/ear	3. Time of 7:18	
	/Medi Examir		4a. Fecility Neme (If not institution, giv	e street and number,)		4b. Cit	y, Town, or	Location of	of Death			County of		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
1			3003 Wells Aven						emere				Bal	time	ore Co	•
D)	Funeral		5. Social Security Number 6. S	ex 7.Ag	ge (In yrs. ia	st birthday) Yrs.	If Und Month	er 1 Year s Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	ay, Year)		Cour	lace (State o	r Foreign
建	Director	ļ	218-36-3385 Usual Residence of Decedent		64	115.					Oct. 1	4,194	11	Mary	land	
	land		10a. State 10b. County		10c. City,	Town or Lo	cation							1	0d. Inside Cit	ty Limits
	Many Hear	tor	Maryland Bal	timore						Edge	emere				1 🗌 Yes	21 No
	be filed within 72 hours after death with the Maryland tall Hygiene. Id other than "natural", or Iteme 23e or 28e-f show event, the Medical Examinar must be multiled at	Director	10e. Street and Number				10f. 2	ip Code				10g. Citi	zen of Wh	at Cour	itry?	
	23a c	alD	3003 Wells Ave	nue				2	1219			Uı	nited	Sta	ates	
	eme	Funeral	11. Maritat Status	12. Was Decedent Armed Forces		. 13.	Was Dec	edent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.))-		Amenic White,	an Indian,	
36	or It	y FL	1 Never Married	1 ☐ Yes 22⊈☐ If Yes, Give	No	1		3 No	Specify:				Specify:	7771101	,	_
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Maryland	Hental Red o	To B	Carl Wilson	Welli	ings				F	ranc	es Eli:	zabet	th Kn	iah	t	
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	s 1 and 2 of Health a item 27 is other train		Mr. Robert Welli	ngs (Sc	on)	300	3 We	lls A	ve.	Edg€	emere, 1	Mary	land	21:	219	
Baltimore,	m O		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Domeual from State		ace of Dispo	sition (N	ame of other place	9)		Date	20c. Lo	cation - Ci	ity or To	wn, Slate	
Ĕ	nit. Pages artment of h ortant: If ite injury or of		4 □Donation 5 □Other (Specif		I	vo Ci	ty C	emete	ry 8	3/5/2	2006		Prov	o, t	Utah	
a	permit. Page Department (Important: If eny injury or once.		21. Signature of Funeral Service Licer	nsee		22	Name	and Addres	s of Facilit	y ral	Home of	f Dur				
Ω.	20E = 9		Head	e la	w.		7922	Wise	Ave.	Du	ndalk,	Mary	land	21	222	
3	Physician /Medical Examiner	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c.	removed to be	ence of): tic ence of): fix te (٨	!eph.	whe !	they					Interval Betwonset and D	
P.O. Box 68760,	The law requires that the death certificate be executed the seen signed by the attending physician and tage 2 should be detached for use as the burral-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Due to (or as d	of pregnan	cy death 3[Ectopic Other (pregnancy specify)				2	23d. Date ('ear
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n O	ding Ph .r After th funeral	inol	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time o Injury		28c. Injury Work			28d. Describe	how injur	y occurred	i		
Division	deatl deatl ctor: / the	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of In	ijury - At hon tc. (Specify)	ne, farm, str	M eet, facto		/es 2 □ I		28f. Location (. City or To			or Rura	l Route Numb	ber,
	To the Hospital or At within 24 hours after d To the Funaral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Example (Check only one)	nysician: To the best niner: On the basis of and manner s	of examination	ledge, deat on and/or in	h occurre vestigation	d at the lim	e, date an	d place, a	and due to the ed at the time,	cause(s) dale and	and mann place, and	ner as st d due to	ated. the cause(s)	
	To the To the To the To the To the To the Comp	X	29b. Signature and title of certifier				2	9c. License	number						Day, Year)	
			Raymundo	r. Mirga	11, h	no		209	350)		7/	28/0	6		
1	21		30. Name and address of person who RAYMUNDO	completed cause of	death (Item :	23a) (Туре, <i>Р</i> М - О	Print)	781	i a	1150	Ave	Be	1670	,	2/22	>
1000	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AIIG 0 3 20	32 Regist	rar's Signatu	ire	arte	,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2°1 Year **Physician** 29 320 PM William D. 2006 /Medical 4a. Facility Name (If not institution, give street and Jown, of Location of Death 4c. County of Death **Examiner** nmore venue 7. Age (In yrs. last birthday) Social Security If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🕶 F 12-30-3043 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 Ia marked othar than "netural", or Itams 23e or 28a-f ahow traumatic avent, the Madical Examiner must by molified at 10d. Inside City Limits MD 1 Yes 2 □ No **Funeral Director** more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **3**50 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 4 Divorced 3 Widowed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ent: If itam 27 Ia marked othar than ' ury or othar traumatic avent, Ins Ma Elementary/Secondary (0-12) lovege (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide Be :ams 2 1550U Method of Disposition 20c. Locati 1 Burial 2 Cremation
4 Donation 5 Other 3 Removal from State 5 Deher (Specify) re of Funera town. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes Division of Vital 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes death. 2 No after death Diractor: / d in by the f 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEI-WUSU MI

AUG 0 3 2006

	1	For State Registrar			State o	of Man	yland		artment rtificate				iental Hy	giene Reg. No.	006	24	1,09
		1. Decedent's Name	e (First, Midd	le, Last)									2. Date of De. Month	Day	Year	3. Time	of Death
Physician /Medica		George	e E. Wa	11ton	1								July	24, 2		2:15	PM M
Examine	-	la. Facility Name (/									Location of	of Death			unty of Death		
	ı	101 Ce	enter F	Place	#307					nda1					1timor		
Funeral	- 1	5. Social Security N		6. Sex	M 2□F			ast birthdey)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, De	y, Year)	Co	npiece (Stete untry)	or Foreign unk
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D *		Usual Residence of 10a. State	10b. County	,		1	Oc. City	. Town or Lo	cation							10d. Inside (City Limits
faryli sto	.	MD	Balti	more				Dund	212							1 □ Ye	s 2. 1 No
the A	90	10e. Street and Nu		LINOLE	:			Dana	10f. Zip	Code				10a, Citizen	of What Co	untry?	
with po a	5	101 Cer		ace	#307				101. 2.0		21222	<u>)</u>			USA	,	
1215-0036 within 72 hours atter death with the Maryland ane. than "naturel", or Items 23e or 28e-1 show the Medical Examinat must be notified at	Funeral Director	11. Marital Status			2. Was Dec	cedent Eve	ar in U.S	S. 13.	Was Deced	lent of Hi	spanic Ori	igin? (Sp	ecify Yes or No	- 14.	Race - Ame	ncan Indian,	
ter d	5	1 Never Marr	ried 2⊟ Mar		Armed F				If Yes, spec	ify Cuba	n, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	1	Black, White		
336 Ir. or	2	3 Widowed			If Yes, G Year or [ive			1 Yes	No X	Specify:			Sp	ecity:whi	te	
21215-0036 d within 72 hours att glene. er than "naturel", or ure Medical Exercit	g e		15. Deceder	nt's Educ	ation			16a. Dece	dent's Usua	I Occupa	ation		unk	16b. Kind	of Business/	ndustry	unk
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ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Itsm 27 is marked other than "naturel", or Items 23e or 28e-1 show other traumatic event, the Medical Examiner must be notified at	0																
lary		19a. Informant's N	ame/Relation	ship (Typ	e, Print)			19b. Maili	ng Address	(Street a	and Numb	er or Run	al Route Numb	er, City or To	own, Stete, 2	îp Code)	unk
Fe, M		Baltimor	e Coun	ty P	olice	Dept							-			-	
of He liter	1	20a. Method of Dis		2 O D		- 1	20b. Pl	ace of Dispendence of the design of the desi	osition (Nan matory or o	ne of ther plac	e)		Date	20c. Locat	ion - City or	Town, State	
Page Dent of the link of the l		1 ☐ Burial 2 14 ☐ Donation	5 Other	Specify)	in st	ate											
Baltimore permit. Pages 1 s Department of He Important: If iter any injury or oth		21. Signature of Fi	onald		nde (Direc	tor	S	2.Namean tate <i>A</i> Litimo	Anato	omy B	oard 2120	655 W.	Balt	imore	Street	
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P.O. Box 68760, that the death certificate be expedition by the attending physician detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was deceder in the past 12 1 Pyes 2 9 Unknown	2 months?	23		birth 2	Fetal	death 3	□Ectopic pr □ Other (sp					23d	I. Date of del Month	very Day	Year
S transport	2	Part II. Other signi	- Williams	tions con	tributing to	death but	not resu	ulting in the (underlying c	ause giv	en in Part	l.		tobacco use Yes 2□N		_	_
w requir	Completed	GE	$\sigma_{\mathcal{D}}$										24a. Was	an 2	24b. Were au	topsy finding	s available
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of Vita Physician: r this certific	o B	25. Was case refe examiner?			ospital: , _	Inpatient	001	ER/Outpatie	nt 3 DC	Oth	000	ursing Ho	th (Check only	idence 6	Other (See		
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Division of to Attending Physalter death. Director: After this in by the funeral d	fica	3 Suicide	6 ☐ Could	d not be	28e. Plac	ce of Injury	· At ho	me, farm, s	reet, factor	y, office			28f. Location (lumber or Ru	ıral Route Nu	ımber,
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To the within 2 To the complet	Me	29b. Signature and	d title of certif	ier			-		296	c. Licens	e number			29d. Date s	igned (Mont	h, Day, Year)	
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Star Registra		31. Date filed (Mo		ir)	32.	Registrar'	s Signa	ture	hast	,	-(•	B4 17	~00.(
Hegistra	-11		AUG 0	0 20	UU	1 Supple	Sal a	No po									

06-05493 Joseph Zubey

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,		1- For State Cell Registrar	rtificate o		id Wichtai i		eg. No.	200	6 2441
Physicia edical Exami	an/	Decedent's Name (First, Middle,Last)	Zubey			2. Date of Dea Month July 28, 2	th	Year	3. Time of Death 0125 hrs
Colcai Exam	1101	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	r Location of Deat			inty of Death	
		Johns Hopkins Bayview Medical Center		Baltimore				N/A	
Funeral Director		5. Social Security Number 6 Sex 7. Age (in yrs I	last birthday)	If Under 1 Year Months Day		1.	,	Foreig	thplace (State or InPennsylvani
Director		218-44-3043 1X M 2 F 61	Yrs	5.		June :	12,194	5 Co	ountry)
any			Town or Local	ion					10d Inside City Limits
and show nce.	or	Maryland Baltimore			Dundalk				1 Yes 2 X No
Maryl.	Director	10e. Street and Number		10f. Zip Code	21222	1	0g. Citizen o	f What Cou	-
ith the 23a or notifi		1854 Marshall Road 11. Marital Status 12. Was Decedent Ever in U	6 142 144		spanic Origin? (S	if . V N-			
21215-0036 hould be filed within 72 hours after death with the Maryland of Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show any utic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? 1 X Yes 2 No			n, Mexican, Puerto			Vhite, etc.	ican Indian, Black,
after d		3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 🗍	Yes 💥 No	specify:		Spec	afy:	White
hours matur Exami	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			ation (Give kind of e. DO NOT use re		16b. Kind o	of Business/	Industry
36 hin 72 e. than "	ıplet		Т э	borer			Stoo	l Ind	13 G + 1077
5-00 ed wit fygien other	Con	17. Father's Name (First, Middle, Last)	" ла.	porer	18.Mother's Nam	e (First, Middle, I			ustry
121 d be fill ental H arked	Be	Joseph John Zubey			Mary	Sapilak			
e, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once	To	19a. Informant's Name/Relationship (Type, Print)			et and Number or				
e, N I and 2 Health item 2			Place of Dispos	sition (Name of ce	e Road emetery,	Date			d 21221 Town, State
Pages ent of int: If		T & Bullar 2 Cremation 3 Kemova irom State	crematory or of	ll Mem.	Gdns 7	/31/200	Mid	dle R	iver, MD
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other transmatic event, the Medica		21. Signature of Funeral Service Licensee	22	lame and Address					
		23a Part I. Enter the disease, or complications that caused the death		922 Wise	e Ave. I	oundalk,	Maryl	Land	21222 Approximate Interval
Physician /Medical		failure. List only one cause on each line.				or reophatory an	031, 31100K, 01	ricart	Between Onset and Death
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760, ficate be g physica the burn	-	IF FEMALE: 23b. Was decedent pregnant in the						te of deliver	´
30x 68' death certifine a tending for use as	cian	past 12 months? 1 Live birth 4 Pregnant at time of de	aath	etal death 3 ther (Specify)	Ectopic pregn	ancy	Mont	.h [Day Year
Vital Records, P.O. Box 68' by sician: The law requires that the death certificate has been signed by the attending of director, page 2 should he detached for use as	Physician	1 Yes 2 No 9 Unknown 9 Unknown							
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ds, equires		Lung disease				24a. Was			itopsy findings available
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of Vital Records, ag Physician: The law require the this certificate has been sineral director, page 2 should by	ပ္ပ	25. Was case referred to medical		26.Plac	e of Death (Check		2 V No	1 Ye	es 2 No
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1 of ling P After funera	L :uc	27. Manner of Death 1 Natural 5 Pending	28b. Time of		Yes 2 No	28d. Describe I	now injury oc	curred	
Division tal or Attendir rs after death al Director: A	cati	2 Accident Investigation 28e Place of Injury - At h	nome farm stre			28f Location (Street and Nu	imber or Ri	iral Route Number, City
Divis	Certification:	3 Suicide 6 Could not be determined (Specify)	iomo, rami, one	or, raciony, omeo	building, oto.	or Town, S		ander or re	nai Rodie Hamber, Ony
E 72 = 1		29a. Certifier 1 Certifying Physician: To the best of my knowled							
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination a and manner stated 29b Signature and title of certifier	and/or investiga			at the time, date			
	2	296 Signature and title of certifier		29c. Licen:	.M.E.		July 28,		nth, Day, Year)
		30. Name and address of person who completed cause of death (Item	n 23a)				23,7 20,		···
624		Pamela Southall, MD Assistant Medical Exami		Penn Street, I	Baltimore, MD	21201			
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Examir	ner	4a. Facility Name (If not institution, give				or Location of Death	1	4c. County of Dea	
ineral	0	9018 Gettysburg La 5. Social Security Number 6. Se		rs. last birthday	College If Under 1 Year		8. Date of Birth	Prince (Jeorge's
rector		159-10-1173	□M 2 KF 88	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, You Oct. 26,	1917 Pe	ennsylvania
A H		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limi
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natural, or teme 23s of 28s-1 enow	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	Country?
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ME LE	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of I	Hispanic Origin? (S can, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
No. of	by F	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify:	White
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other traumatic		19a. Informant's Name/Relationship (T) Carol Arndt Gray					ral Route Number, C		Zip Code) :y1and 2074
ther	1 1	20a. Method of Disposition	/ Daughter	. Place of Dispe	osition (Name of			c. Location - City or	
ō		tX☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State Sp	cemetery, cre ring Hi	II Memor	y 7/17			
글 .		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens	100	rdens	2. Name and Addre		/2006 Hebert E. Ev	ebron, Ma	
any Injui		1 St Pken	-				d, Bowie,		
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2 should	င္ပ	25. Was case referred to medical					1 □ Yes 2 0		s 2 No
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ge 2 should	tification: To		28e. Place of Injury - Al	cifv)			,, -	,	
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ge 2 should	ical Certification: To	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Accident investigation 6 Could not be determined	building, etc. (Speriscian: To the best of my kiner: On the basis of exami	(nowledge, deat	h occurred at the til	me, date and place,	and due to the cause	e(s) and manner a	s stated,
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State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JOHN HACKETT ANDERSON JULY 18 2006 11:40PM M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 10571 OLD CORDOVA ROAD EASTON TALBOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 7, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours Yrs 217-14-8474 Director 82 MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director TALBOT EASTON MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10571 OLD CORDOVA ROAD 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or Ites 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coltege (1-4or 5+) Elementary/Secondary (0-12) U.S. GOVERNMENT 11 MILITARY OFFICER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JOHN ANDERSON AGNES OTHELIA SKINNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun JOHN M. ANDERSON/SON 402 WEST GLENVIEW DRIVE, SALISBURY, NC 28147 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) MD VETERANS CEMETERY 7/25/2006 HURLOCK, MARYLAND 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Parkinsons Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) s after death.
I Director: After this ce
of in by the funeral direc Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200No P 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 To the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7-20-06 10051172 6+IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JORGE H. ABREGO M.D. 598 CYNWOOD DRIVE, EASTON, MD 21601 gistrar's Signature 31. Date filed (Month, Day, Year) 32. JUL 2 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** RUTH LEONA BROOKS JULY 18, 2006 5:55A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 7500 WOODMONT AVE BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month Day, Year) DEC. 9, 1925 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** NEW YORK 1 ☐ M 2 ☐ XF 057-22-5658 80 Director Usual Residence of Decedent with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ih and Mental Hygiene. 27 is marked other then "natural", or Iteme 23a or 28a-f ehow traumatic event, tre Medical Examinat must be notified at 1 ☐ Yes 2 ☑ No Director MARYLAND MONTGOMERY BETHESDA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES OF AMERICA 20814 7500 WOODMONT AVE. #616 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL WORKER SOCIAL WORK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: if Item 27 is marked o CELIA WEINSTEIN ABRAHAM DAVID BENJAMIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 600 NORTH ALABAMA ST. #503 INDIANAPOLIS, IN 46204 ERIC BROOKS - SON other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition PARKLAWN CHARACTER TO THE PARK 1 🛴 Burial 2 □ Cremation 3 □ Removal from State 07/20/06 ROCKVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) MENORAH GARDENS 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service eny in 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD20904 Approximate Interval Between Onset and Death 23a. Part 1. Egter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Immediate Cause (Final **Physician** LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien Physician/Medical use as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No page 5 has certificate 1 Yes Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပို 2₹ No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the Director: 6 Could not be determined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after or To the Funerel Direc completely filled in by 4 Homicide 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JULY 19, 2006 D0052509 12 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6410 ROCKLEDGE DRIVE, SUITE 308, BETHESDA, MD 20817 SUE D. KANTER, M.D. 32/Registrar's Signature 31. Date filed (Month, Day, Year) JUL 2 0 2006 Registrar

		•	1 = For State Registrar	State of M	/larylan			of Health of Deat			giene Reg. No.	2006	24	
			1. Decedent's Name (First, Middle, Last)							2. Date of Dea	athDay	Vane	3. Time o	Death
	Physici /Medic		Jane L. Botts							July	17,	2006°	6:24	Ам
	Examin		4a. Facility Name (If not institution, give	street and numbe	or)		4b. City, 1	own, or Location	on of Death	-	4c. 0	County of Deat	h	-
			Holy Cross Hospita	al			Silve	er Sprin	ng		Mo	ntgome	ry	
H	Funeral		5. Social Security Number 6. Sex		Age (In yrs. I	ast birthday)	If Under	1 Year If Und Days Hours	der 24 Hrs.	8. Date of Birt	h V Vearl	9. Birt	hplace (State wintry) h • D • G •	or Foreign
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	D _		Usuel Residence of Decedent		10. 00	-								
	ahow	_	10a. State 10b. County			, Town or Lo							10d. Inside C	ıty ∟imits 2 ∏ No
	Ba-f	cto	D.C. N/A		Wa	ashing	_							
	or 2	Director	10e. Street and Number				10f. Zip				-	en of What Co	-	
	23a		1325 Upshur Stree		#211			011				ed Sta		
	er de	Funeral		 Was Deceder Armed Force 	s?	S. 13. \	Nas Decede f Yes, speci	ent of Hispanic (fy Cuban, Mexic	Origin? (Spec can, Puerto F	cify Yes or No- Rican, etc.)	. 1.	 Race - Ame Black, Whit 		
9	s afte	by F	1 Never Married 2 Married 3 Widowed 4 XDivorced	1 ☐ Yes 2¥ If Yes, Give Year or Date:	_		1 □ Yes 2	☑ No Speci	ity:		3	Specify: B1	ack	
215-0036	J within 72 hours after death with the Maryland jien. Then "naturel", or Items 23s or 28s-(show the Madical Examiner must be notified at	D D	15. Decedent's Edu		s:	162 Dece	tont's Heuri	Occupation			16h Kin	d of Business/	Industry	
Ϋ́		Completed	(Specify only highest grade			(Give	kind of work	k done during m e retired)	nost of workin	g	IOU. NIII	1 01 Busilless	muustry	
7	filed within Hygiene. other then "	ᇤ	Elementary/Secondary (0-12)	College (1-4c	or 5+)		ograpl				Fede	ral Go	vernmer	ıt
ט ס	200	ပိ	17. Father's Name (First, Middle, Last)				-61		ther's Name	(First, Middle,	_			
ā	d be antal ced o	To B	Henry C. Burrell					Ве	ernice	King				
<u></u>	mari mati	F	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailin	ng Address	(Street and Nun	nber or Rural	Route Numbe	r, City or	Town, State, I	Zip Code)	
Maryland	d 2 s th ar treu		Carlos E. Botts	(son)			•	n Place						1
a)	Heel Heel tem		20a. Method of Disposition	\	20b. P	lace of Dispo	sition (Nam	e of		ate		ation - City or		
ᅙ	8 E E E		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from Sta		emetery, cren ESADEA		ematory	7/21	/2006	Belt	sville	. MD	
saitimore,	rtan Injur		21. Signature of Funeral Service Ligan	1				Address of Fac	1					
n n	permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked oth any injury gogither treumatic event once.		Dun 101	high	148			eorgia A						012
	_		23a. Part Enter the disease, or compli	ications that caus	sed the death							60011	Approxima	
			23a. Part Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final							,			Interval Ber Onset and	
1	Physician /Medical		disease or condition resulting in death)			e Hear	t Fai	lure					years	
	Examiner				as a consequ								The St. of Section 2	
		<u>_</u>	Sequentially list conditions,		iomyo								years:	
	ted nsit	Examiner	Sequentially list conditions, if any, leauning to immediate cause. Enter Underlying Cause (Disease or injury	,		,								
	al-tra	Xa	that initiated events resulting in death) Last		as a consequ	uence of):								
8/60	death certificate be executed e attending physician and nd for use as the burial-transit	dicai												
200	ficate phy s the	ed												
XOR	eath certific attending p for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcon							23	3d. Date of del	ivery	
ň	atte d for	cla	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant]Ectopic pre] Other (spe					Month	Day	Year
o.		lsk	9 Unknown	9□ Unknown										
1	res that the de signed by the a be detached i	by PI	Part II. Other significant conditions cor	ntributing to death	but not resu	ulting in the u	nderlying ca	use given in Pa	ırt I.	23e. Did to	obacco us	e contribute to	the cause of	death?
g	n sign	D D	Atrial Fibrillat	ion						1 🗆 Y	/es 2 □	No 3□Pr	obably 4x	Unknown
င္ပ	w requir been si should I	ete	Anemia of chroni	c nature	2					24a. Was	an	24b. Were au	topsy findings	available
of Vital Records,	ysicien: The law requires that the is certificete hes been signed by the director, page 2 should be detach	Completed	Urinary Tract In	footion							rmed?	prior to death?	completion of a	ause of
g		ပိ	25. Was case referred to medical	Tection				ne Die	and of Dogsh	Check only o	20 No	1 ☐ Yes	2 No	
>	s cert irect	8	examiner?	lospital:	atient 2 🗆	ER/Outpatien	3 700	-		ne 5 ☐ Resid		□Other /See	0.64)	
ō	Attending Physicien: r death. sctor: After this certifici by the funeral director, i	Ë	27. Manner of Death	28a. Date of Ir	njury	28b. Time of		Sc. Injury at Work?		8d. Describe h			ony)	
<u></u>	th.: After	ig l	1XXVatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, I	Day Year)	Injury	м	work? 1 ☐ Yes 2	□No					
Division	or Attendi after death. Director: A in by the fu	Hica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of	Injury - At ho	me, farm, str	eet, factory,	office	2	8f. Location (S		Number or Ru	ıral Route Nun	ber,
	al or At a after o il Direct d in by	Certification:	4 Homicide	bullaing,	etc. (Specify	′)				City or Tow	m, State)			
	hours inera y fille		29a. Certifier 1 Certifying Phys	sician: To the be	st of my kno	wledge, death	occurred a	t the time, date	and place, a	nd due to the	cause(s) a	ind manner as	stated.	
	To the Hoepital or Att within 24 hours after d To the Funeral Direct completely filled in by t	edical	(Check only 2 Medical Exami	ner: On the basis and manner	or examinal stated.	iion and/or in	vestigation,	in my opinion, d	death occurre	at the time, o	uate and p	nace, and due	to the cause(S)
	To the To the Comp	Σ	29b. Signature and little of certifier				29c.	License numbe	er		29d. Date	signed (Mont	h, Day, Year)	
)	5		MAGIN	n			D	32332			Ju1y	17, 2	006	
			30. Name and address of person who co		-						1 1 2 2 2 2			
			Suresh K. Gupta,					#220,	Silver	Spring	g, MD	2090	2	
	Sta		31. Date filed (Month, Day, Year)	32. Fiegi	strar's Signa	ture do	selle?	-						
	Regist	ar	JUL 2 0 20	DUC TO	CARL A	2. 12/	17.2							

			For State Ragistra/MEND#11perFH7/	State of Mar	yland / Den	_	Health and	Mental Hy	giene 006	24415
			1. Decedent's Name (First, Middle, Last,					2. Date of Dea	ath Day Year	3. Time of Death
e Agr	Physici /Medic		Lewis	Battle					15, 2006	9:52P M
	Examin		4a. Facility Name (If not institution, give				or Location of Dea	th	4c. County of Dea	
· ·			Washington Adv				na Park	S 0 D-1(Bin		George
	Funeral Director		5. Social Security Number 6. Sec. 239-34-0689	7. Age (7. Ag	'In yrs. last birthday, Yrs.	Months Days				rthplace (State or Foreign ountry) N.C.
	/land		10a. State 10b. County	1	Oc. City, Town or L	ocation				10d. Inside City Limits
	Man a-fsh	io	D.C. N/A		Washin	igton				1 X Yes 2 □ No
	3a or 284	Il Direc	10e. Street and Number 211 Underwood	Street,	N.W.	10f. Zip Code 200	12		10g. Citizen of What C	ountry?
"	d within 72 hours after death with the Maryland Jiene. rithan "natural", or items 23a or 28a-f show Ite Madical Exertires must be rediffed at	Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Ev Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give	er in U.S. 13.	Was Decedent of		Specify Yes or No- rto Rican, etc.)		te, etc.
21215-0036	2 hours a atural, o	þ	3 ∰Widewed - 4 □ Divorced	Year or Dates:	16a Dece	1 ☐ Yes 2 No	nation		Specify: I 16b. Kind of Business	
215	within 7. ene. than "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)		e kind of work done DO NOT use retire		orking		_
2		S	12th		Pos	stal Ser			U.S. Gov	ernment
Maryland	B a b ≥	To Be	17. Father's Name (First, Middle, Last) Henry Bat	tle				me (First, Middle, Draff)	Maiden Sumame) Ln	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (T) Deborah Dudley			ing Address (Stree Underwo			or, City or Town, State, 20012	Zip Code)
Baltimore,	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Disp cemetery, cre Harmony	osition (Name of ematory or other pla	rk 7/2	Date 22/06	20c. Location - City of Landover	
Baltii	permit. Page Department Important: If any injury o		21. Sign tre of Funeral Service Licens		2	The Hou	ess of Facility	William: treet, I	s Fun. Sv	•
	Physician		23a. Fart1. Enter the disease, or composhock, or heart failure. List only o Immediate Cause (Final disease or condition		,	nter the mode of dy	ing, such as cardia	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death
3760,	Medical Examiner hysicien and the burial-transit	Ilcal Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a control of the contr	consequence of): Len consequence of): Len consequence of):	in g Nisea				menous
P.O. Box 68	The law requires that the death certificate the bas been signed by the attending phy tage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify)	су		23d. Date of de Month	Day Year
	quires that n signed b uld be deta	þ	Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying cause g	iven in Part I.		obacco use contribute (es 2 No 3 F	to the cause of death?
I Records,		Completed						24a. Was autop perfo 1 □ Yes	rmed? prior to death?	utopsy findings available completion of cause of s 2 No
Vital	ysician: Th is certificate director, pag	Be (25. Was case referred to medicat examiner?					ath (Check only o	ne)	
of	ling Phys	tlon: To	27. Manner of Death 1 ☑ Naturat 5 ☐ Pending	1 Inpatient 28a. Date of Injury (Month, Day)	28b. Time	of 28c. Inju			dence 6 Other (Sp now injury occurred	ecify)
Division	il or Attending after death. I Director: After d in by the fune:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, si (Specify)	treet, factory, office		28f. Location (S City or Tox	Street and Number or F vn, State)	Bural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in I	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Example 1	sician: To the best of ner: On the basis of e and manner state	xamination and/or is	ith occurred at the t nvestigation, in my	ime, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	Fo the vithin Fo the	Me	29b. Signature and title of certifier				se number		29d. Date signed (Mor	
)	3		> Thulus 1	too m		558	03		7/15/6	6
			30. Name and address of person who c	ompleted cause of dea	ath (Item 23a) (Type	, Print)				
4	Sta	ate	Kimberly Treat 31. Date filed (Month, Day, Year) TUL 2 0 20	32 Registrar	S Signature	and Dr.	Rockvi	lle, Md	20850	
10 A	Regist	rar	JUL 2 U 20	Ub Fin CARL	15. 16	Sec. Berry				

			1 - For State Registrar		of Marylai		artmen rtificat					Reg. No.	006	24416
	Physici /Medic	al	1. Decedent's Name (First, Middle M ADEZINE	E.		BE	24				2. Date of De Month	1) Day	2006	3. Time of Death 0630 M
	Examir Funeral	er	4a. Facility Name (If not institution Anne Arundel M 5. Social Security Number	edical Ce		. last birthday)	Ann If Under		S If Under	24 Hrs.	8. Date of Bir	A ₁	nne Arur	lace /State or Foreign
	Director		578-36-3195 Usual Residence of Decedent 10a. State 10b. County Maryland Anne	ı⊡м 2 5 4∓ Arundel	10c. C	75 Yrs. Sity, Town or Logewater	Months	Days	Hours	Min.	Novembe	er 15		od. Inside City Limits
	d within 72 hours after death with the Maryland Jene. Ir than "natural", or Items 23a or 28e-f show The Medical Exactinat trust be rediffed at	Funeral Director	10e. Street and Number 3608 Second A	venue	edent Ever in U			1037	panic Ori , Mexicar	igin? (Spe	cify Yes or No	1	en of What Coun USA 4. Race - Americ Black, White,	an Indian,
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Maryland 2	be file ital Hyg id othe event,	To Be Co	17. Father's Name (First, Middle, Joseph Welfo	rd Rye					Ann	ie		, Maiden S steen	umame) Woo	
Baltimore, Mar	of Health and Item 27 la		19a. Informant's Name/Relations Joyce McTighe 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)	- Daughte	20b.		dgeto	wn Be	end,	Coro	nado, (CA 927	Town, State, Zip 118 ation - City or To 1sonvill	wn, State
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ords, P.	sen sign	by	Part II. Dther significant condition	ns contributing to d	eath but not re	sulting in the u	nderlying c	ause giver	in Part I.		150	Yes 2	No 3 ☐ Proba	
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Division of V	tending Physical Physical Corrections the funeral distribution of the funeral distribu	ertification: To B	examiner? 1 Yes 2 No 27 Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could n	28a. Date (Mon lation	of Injury th, Day Year)	28b. Time o	f 2	A Other 8c. Injury a Work? 1 [] Ye	4 □ Nu	rsing Hon 2 No	ne 5 Resi	dence 6 [□Other (Specify occurred	
Div	To the Hospitel or Attenwithin 24 hours after deati To the Funerel Director: completely filled in by the	O	4 Homicide determ 29a. Certifier 1 Certifyin	g Physician: To the	of Injury - At hing, etc. (Speci	owledge, deat	occurred.	at the time	, date an	d place, a	City or To	wn, State)	nd manner as sta	ated.
	To the Ho within 24 h To the Fu completely	Medical	(Check only 2 Medical 29b. Signature and title of certifier	Examiner: On the b	asis of examination of stated.	ation and/or in	vestigation,	in my opir	nion, dear	th occurre	d at the time,	date and p	lace, and due to signed (Month, L	the cause(s) Day, Year)
			30. Name and address of berson	Men Completed cause. Late N	se of death (Ite	m 23a) (Type,	Print	XA	215	130 His	ш./Д.	An	NO PAL	Maryar
	Sta Registr		31. Date filed (Month, Day, Year) JUL 19		legistrar's Sign		ن دا	, ,,,		i la	PWRY	12 10	-FIF (UL)	ייעיייעויי

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death BURTON **Physician** MILDRED 2006 JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis Il Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 18, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 218-F Months 217-07-2131 88 Yrs. Director 1918 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at Anne Arundel Arnold Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 629 Breton Place 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: 2 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other then "natany njury or other traumatic event, I'm Medica one. 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Clark Etta Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Burton IV,/Son Bowie, MD 20715 16320 Banbury Lane 20a. Method of Disposition 20b. Place of Disposition (Name of July 19, 20c. Location - City or Town, State cometery, cromatory or other place)

Lakemont Mem. Gardens 1 XBurial 2 ☐ Cremation 3 ☐ RemoveL{rom State Davidsonville, MD 4 □ Donation 5 □ Other (Specify) 21. Signat re of Funeral Se de Licensee Parranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral H Severna Park, MD 21146 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List pny one cause on each line. NEUMUNIA. Immediate Cause (Final Pnysician sease or codition resulting in eath) /Medical (or as a consequence of) 70 Examiner ALLURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Tes 2 No 3 Probably 4 Nunknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate Division of Vital 2 No 1 ☐ Yes 2 ☐ No 1 Yes the Hospital or Attending Physician: After this certification, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient this 2 ER/Outpatient 3 DOA 2Ba. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident Certification: 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No Director: A 6 Could not be determined 3 Suicide 2Be. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281 Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certif 29c. License number DEFENSE HIGHWAY ANN eted cause of death (Item 23a) (Type, Print) 445 31. Date liled (Month, Day, Year) 32. Agistrar's Signature Registrar

Please Type or Print in Black Indelible	Ink. Ensure All Copies Are Legible.
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			For State Registrar	State of	Maryland /		rtment of tificate of			giene Reg. No:- 0 0 6	24418
		rig A	Decedent's Name (First, Mid	die, Last)					2. Date of De		3. Time of Death
	Physici /Medic	4	JAMES F. BAR	TLEY					7	17 06	21316 M
	Examin	- 2	4a. Facility Name (If not instituti					or Location of Deat	h	4c. County of De	
* 1,0			5. Social Security Number		'AL 7. Age (In yrs. last I	hirthday)	BER If Under 1 Yea	LIN If Under 24 Hrs	8. Date of Bird	WORCES	TER inthplace (State or Foreign
	Funeral Director		220–38–4544	1 X M 2 ☐ F	64	Yrs.	Months Days		(Month, Da	y, Year)	SHINGTON D.C.
-	D D		Usual Residence of Decedent								
	arylan show	_	10a. State 10b. Coun	•	10c. City, To						10d. Inside City Limits 1 ☐ Yes 2 No
	he M.	Director	MD WOR	CESTER		MUSTE	10f. Zip Code			10g. Citizen of What (
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	thin 72 hours after death with the Maryland e. en "neturel", or items 23s or 28s-f show Medical Examirar must be Inditied at	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S.	13. W		Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No		nerican Indian,
٥	or ite	교	1 Never Married 2 Ma	Armed For 1 XYes If Yes, Give	2 🗌 No		Yes, specify Cu		to Rican, etc.)		
215-0036	hours after turel', or ite	d by	3 ☐ Widowed 4 🛣 Divorce	ed Year or Da	ites:					Specify: WI	
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7	₹ 5 €	E C	Elementary/Secondary (0-12	College (1	-4or 5+)		DYMAN	00)		CONSTRUCT	TON
2	il Hygie other	Be Co	17. Father's Name (First, Middle			шы	DITION	18. Mother's Na	me (First, Middle,	Maiden Sumame)	LON
aryland	0 0 0	6	JAMES H. HA	RPER				HELEN	M. ZIMME	ERMAN	
a	2 should and Men Is marke		19a. Informant's Name/Relatio							er, City or Town, State	Zip Code)
Ξ,	s 1 and 3 if Health item 27 other tr		HELEN GUSSIN	/MOTHER				OURT, EAS			-
altimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1	n 3 Removal from 5		tery, crem	ition (Name of atory or other pl	1	Date	20c. Location - City of	r Town, State
Ē	tment tant:		`4 ☐Donation 5 ☐ Other	(Specify)			S CEMET		4/2006	HURLOCK,	MARYLAND
Ba	permit. Pages Department of H Important: If ite any injury or of		21. Signature meral Service	eg Licente		FE	Name and Add	HELFENBEI	N & NEWN	NAM FUNERAL MD 21601	HOME PA
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	/Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequenc	ce of): ce of):	IN	FIT RCT	ION		Onset and Death FEW HOURS
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Vita		O	25. Was case referred to medi	cal				26. Place of De	ath (Check only o		33 22 113
	S D	To B	examiner? 1 ¥Yes 2 ☐ No	Hospital:	npatient 2 ER/	Outpatient	3 □ DOA C	ther: 4 Nursing I	Home 5 ☐ Resid	dence 6 Other (Sp	ecify)
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\leq	l or Attendate death Director:	ertif	4 Homicide dete	mined 200. Flace	of Injury - At home, ng, etc. <i>(Specify)</i>	, rarm, stre	евт, тастогу, оптс	Ð	City or Tox	Street and Number or i wn, State)	nurar noute Number,
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}	- >- 0		In oth.	C. The	utt m	1	7	06241		7-18-	-06
,			30. Name and address of person	on who completed caus	e of death (Item 23)	a) (Type, I	Print)	, , , ,		-	
1	+1 VA		DOROTHY		WOPTH	N	1.0, -	703 SNO	W ST.	SMOW HILL	MD. 21865
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			For State Registrar	State of M	Marylan		artment o rtificate		and Mer		ene g. No.	24420
ı	Physici	an	1. Decedent's Name (First, Middle,	-				-		Date of Death Month ULY 1		3. Time of Death
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	Examir Funeral Director	ier	4507 Winding	Brooke La	ane	last birthday) Yrs.	Loth: If Under 1 You Months Da	ear If Under 2	24 Hrs. a	Date of Birth (Month, Day, 0) / 6 / 192	Anne Ar	rundel httplace (State or Foreign ountry)
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	Maryland	tor	Maryland Anne Ar	undel		y, Town or Lo hian	cation					10d. Inside City Limits 1 ☐ Yes 2√√No
	3a or 28	al Dire	10e. Street and Number 4507 Winding Bro	oke Lane			10f. Zip Cod	2071	1	10	g. Citizen of What C USA	ountry?
030	be filed within 72 hours after death with the Maryland nat lygiene. Id other than "natural; or itams 23a or 28e-f ehow event, the Mudical Examinar meat he notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☼ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Amed Force 1 Myes 2[If Yes, Give Year or Dates	s? ∃No WWI	1	Was Decedent f Yes, specify (of Hispanic Orig Cuban, Mexican, No Specify:	gin? (Specify , Puerto Rica	Yes or No- an, etc.)	14. Race - Am Black, Whi	
9500-61212	thin 72 ho e. nn "natur. Medical	Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)	Education grade completed) College (1-40	r 5+)	(Give		ne during most tired)		1	6b. Kind of Business	/Industry
	e filed within al Hygiene. other than '			2		Elect	ronic E	ngineer			Johns Hopk	ins Univ.
yland		To Be	17. Father's Name (First, Middle, La Henry G. Chapman							rst, Middle, M C. Hunt	aiden Sumame)	
, Mar	2 m m		19a. Informant's Name/Relationship Katherine Chapma			4507	Winding	g Brooke			City or Town, State, an , Md . 2071	
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	Physician		23a. Part . Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	ly one cause on each	line.	h. Do not ente	er the mode of	dying, such as c	cardiac or re	spiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	_ d	3 S C A as a consequence		G					
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VII	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:						heck only one		
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	To the To the comp	Me	29b. Signature and title of certifier	- D	OR			ense number	73	296	d. Date signed (Mont	**
		į	30. Name and address of person wh	o completed cause of	death (Item	23a) (Type, I	Print) Rob		enfiel	d,M.D.	2/17/	
·w	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signa		Sand a	muly	045	VX	21701	

			. For	State of M	aryland						ntal Hyg	iene	01101
			For State Registrar			Ce	rtificate	of L	Death			eg. Nó UUD	4444
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Ç.	Examin		4a. Facility Name (If not institution, S PLEASANT VIEW N 40 OLD NATI	ive street and number,	OME				Location of	of Death		4c. County of Dea	ath
	Funeral		5. Social Security Number 6	Sex 7. A	ge (In yrs. last	birthday	MOU If Under	1 Year	If Under	24 Hrs. 8.	Date of Birth	9. Bi	rthplace (State or Foreign
	Director		255-12-3723	1 □ M 2 □ XF	87	Yrs.	Months	Days	Hours	Min.	ctobe	^{9. Bi} 29,1918	Georgia
	and ***		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or L	ocation						10d. Inside City Limits
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	th the	Funeral Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of What C	country?
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036	ours af	by I	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	No 🔯	Specify:			Specify: W	hite
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or itams 23s or 28a-f show isa Madical Exarti men nast te molified at	Completed	15. Decedent's (Specify only highest of	Education grade completed)	1	(Give	edent's Usual e kind of worl DO NOT us	k done d	lurina mosi	t of working		16b. Kind of Business	s/Industry
121	within iene. than	dwo	Elementary/Secondary (0-12)	College (1-4or	5+)		Loan 0	,				Credit 1	Union
br	a filed al Hyg other	Be C	17. Father's Name (First, Middle, La	st)						er's Name (F	irst, Middle,	Maiden Surname)	
ylaı	ould b Menta	To	Thomas Hall								Carte		
Maryland	d 2 sh th and th and traum		19a. Informant's Name/Relationship Janet A. Pokorr				ing Address 2 Bent					r, City or Town, State, 111e,PA 1	
ē,	s 1 an f Heal item 2 other		20a. Method of Disposition		20b. Place	e of Disp	osition (Name omatory or other	e of	I	Date	-	20c. Location - City or	
Ē	Page nent o ant: If ury or		1 Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spe		9	-	metery			07/22/	2006	Omega, G	A
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 Is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic evant. Its Medical Excitation into the rediffical and once.		21. Signature of Funeral Service Lie	ensee		2	2. Name and					Evans Fundowie, MD	eral Home 20715
L			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that cause ly one cause on each	d the death. [Do not en	nter the mode	of dying	g, such as	cardiac or re	spiratory arr	est,	Approximate Interval Between
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Вох	death certifica e attending ph id for usa as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant a	2 Fetal de	ath 3	□Ectopic pre					23d. Date of de Month	elivery Day Year
o.	that the dei	hysic	1 ☐ Yes 2 ☐ N o 9 ☐ Unknown	9□ Unknown	.,								
s, P	S 7 0	by	Part II. Other significent condition	0-	but not resultin	ng in the	underlying ca	use give	on in Part I.	41.4	f .	bacco use contribute t es 2□No 3□P	robably 4 _Unknown
ord	w require been sig should b	eted	12 12 12 CINCO	y acid	rago	100	, 05	761	/ Q !	1 ras	24a. Was a		
Vital Record	The law ate has page 2:	Completed	HIZheimer								autops perform	med? death?	
ita		BeC	25. Was case referred to medical examiner?	Si					26. Place	of Death (C	heck only on		3 20110
of V	ys dills	P.	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpat		Outpatie			4 🖭 NU			ence 6 Other (Spe	ecify)
	Attending in death.	tlon	1 Natural 5 Pending 2 Accident investiga	28a. Date of Inj (Month, Date)	ay Year)	Injury	M	3c. injury Work 1 🔲 ۱	:?ີ່ ∕es 2 🔲 I		. Doscillo in	ow injury occurred	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could no 4 Homicide determin	286. Place of Ir	njury - At home etc. (Specity)	e, farm, st	treet, factory,	, office		28f.	Location (Si City or Town	treet and Number or Fi n, State)	Tural Route Number,
	Hospital of the hours all Funeral Districted filled in		29a. Certifier 1 Certifying	Physicien: To the bes	t of my knowle	dge, dea	th occurred a	at the tim	e. date an	nd place, and	due to the c	ause(s) and manner a	s stated.
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Ex	eminer: On the basis and manner s	of examination		nvestigation,	in my op	oinion, dea		at the time, d	ate and place, and du	e to the cause(s)
)	with Con	2	29b. Signature and title of certifier	1000	w W	(n)	1	20	65	88		9d. Date signed (Mon	3/06
			30. Name and address of person with the LUIH of LCC	in my	D 95		old 1	Ana	upol	K P4	wl.	Ellicott C	inil 21044
	Sta Registi		31. Date filed (Month, Day, Year) JUL 19		trar's Signature		med						

DHMH 17 Rev 1/2001

State

Registrar

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Steehen 31. Date filed (Month, Day, Year)

KotiL

25 2006

OME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA

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251

32. pgistrar's Signature

Antietum

			State of Maryland / Dep	artment of Health and Menta		ie.
		_	1 - State Ragistrar Ce	rtificate of Death	Reg. No. 201	06 24423
	Physicia	an	1. Decedent's Name (First, Middle, Last) Clarence Albert Crawford		1 4 4	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of	Death
			Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Hagerstown If Under 1 Year If Under 24 Hrs. 8, Da	Washi	
	Funeral Director		214-28-0979 Usuel Residence of Decedent	Months Days Hours Min. (Ma	te of Birth onth, Day, Year) rch 20,1931	9. Birthplace (State or Foreign Country) Maryland
	yland how		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	he Ma	ecto	Maryland Washington Hag	erstown 10f. Zip Code	10g. Citizen of Wh	1 ☐ Yes 2⊠ No
	h with 1	al Dir	17311 Amber Drive	21740	USA	at Country:
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Importent: if Item 27 is marked other then "neturel", or Items 23a or 28a-f show supprightry or other traumatic event. The Medical Examinations is notified at ODGE.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 1950-51	Was Decedent of Hispanic Origin? (Specify Y. If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☒ No Specify:	es or No- etc.) 14. Race Black, Specify:	- American Indian, White, etc. white
2-0	72 ho	eted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of working DO NOT use retired)	16b. Kind of Bus	iness/Industry
21215-0036	within iene. then	ршо	Flementary/Secondary (0-12) College (1-4or 5+)	nine operator	truck	mfg.
Maryland 2	uld be filed Mental Hygirked other	To Be C	17. Father's Name (First, Middle, Last) Clarence E. Crawford	18. Mother's Name (First, Edith Goss	, Middle, Maiden Sumame, ard)
Man	12 sho h and ! 7 le ma	·		ing Address <i>(Street and Number or Rural Rout</i> 11 Amber Dr., Hagerst	· ·	
	s 1 and f Healt ltem 2		20a. Method of Disposition 20b. Place of Disposition			ity or Town, State
Baltimore,	Page ment c tent: If		4 Donation 5 Other (Specify) Rest Hav	en Cemetery 7/25/06		wn, Maryland
Ball	permit Deper- Impor- eny In		* cost Menned	415 E. Wilson Blvd.,		
1	Physician /Medical Examiner		23a. Part 1. Enter the disease, of complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	MCeV	ratory arrest,	Approximate Interval Between Onset, and Death
8760,	certificate be executed nding physicien and use as the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a gonsequence of): c. Due to (or as a consequence of):			
P.O. Box 68	death e etter id for u	Completed by Physician/Medi		□Ectopic pregnancy □ Other (specify)	23d. Date Mont	•
	requires that the een signed by th hould be detache	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	3e. Did tobacco use contrib	oute to the cause of death?
Division of Vital Records,	e la hes le 2	Complete			performed? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death (Che		
o	Phys this aldi	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	HIL SEL DOX 4 TRUISING FIOTHE S	B Residence 6 ☐ Other rescribe how injury occurred	· · · · · · · · · · · · · · · · · · ·
sion	eath. or: After the funer	catio	2 Accident Investigation	M 1 Yes 2 No		
Divi	s after d el Direct ed in by	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	ocation (Street and Number ity or Town, State)	or Rural Route Number,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu	edicai	29a. Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge, dea 2 Madical Examinar: On the basis of examination and/or in and manner stated.			
	To the within To the comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type	D 5 2 3 2 3	1/2//	0
0	H7+1		Dr Waseem 1126 Opal	Court Hagersto	own Mary	land
	Sta Registi		31. Date filed (Month_Day, Year) 32. Registrar's Signature	hacks.		

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryland		rtment tificate			nd Mer			06	24424	
	Physici	an	1. Decedent's Name (First, Middle, Last)							Date of Death Month ULY 16	Day	Year	3. Time of Death	
Sugar	/Medic	al	LILLIAN MARIE DEAN 4a. Facility Name (If not institution, give str	not and number		4h City	Town or	Location of		OLY 10	200 4c. County		12:35 P M	
	Examir	er	SCHUYLER HOUSE	set and number)				HILL	Dogin		QUEEN		_	
	Funeral Director		5. Social Security Number 6. Sex 1 1 N	7. Age (In yrs. las	t birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	4 Hrs. 8. Min. 0	Date of Birth (Month, Day, 4/08/1	929	9. Birth	place (State or Foreign intry) MD	
	pur 3		Usual Residence of Decedent 10a. State 10b. County	10c City	Fown or Loc	cation							10d. Inside City Limits	_
	Maryli f sho	o	MD QUEEN ANN		UEEN A							;	1 □ Yes 2X□ No	
	r 28a	Director	10e. Street and Number			10f. Zip	Code			10	g. Citizen of V	Vhat Cou	intry?	_
	23a c	raiD	1910 RUTHSBURG ROA	D		216	57			U	SA			_
5-0036	be filed within 72 hours after death with the Maryland stal Hyglene. do other than "neturel", or Items 23a or 28a-f show event, the Midfred Examiner must be notilized at	by Funeral	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 N No If Yes, Give Year or Dates:	If	Vas Deced Yes, spec	ify Cubar	spanic Origi n, Mexican, Specify:	in? (Specify Puerto Ric	y Yes or No- an, etc.)	Blac	e - Amer k, White . WH]		
ည်	72 ho	eted	15. Decedent's Educa (Specify only highest grade of		16a. Deced	kind of wor	k done d	urina most d	of working		16b. Kind of Bu	siness/li	ndustry	
121	within the the the the the the the the the the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		MEMAK	,				OWN 1	HOME		
Q 2	filed v Hygie other 1	ပိ	12 17. Father's Name (First, Middle, Last)		по	MEMA		18. Mother	's Name (F	irst, Middle, N	faiden Sumam			_
an .	S should be filed with and Mental Hygiene is marked other tha aumatic event, Ine	To Be	FRED MELVIN HALL					MA	RIE S	EYMOUR				
Maryland 2121	s 1 and 2 should it Health and Men Item 27 is marke other traumatic.		19a. Informant's Name/Relationship (Type	, Print)		-					City or Town,			
	and and mark		MR. HOWARD A. DEAN	· · · · · · · · · · · · · · · · · · ·				G ROA			NE, MD			_
altimore,	0 0		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Rer	noval from State	se of Dispos netery, crem LAWN I	atory or of	ther place		Date 7/20/		20c. Location - EASTON ,	-	own, State	
	permit. Pag Department Important: I any Injury o		4 □Donation 5 □Other (Specify) 21. Signatur of Finantal Service Licensee	1/0-/	22	. Name an	d Addres:	s ol Facility		-				-
ä	Deg du de de de de de de de de de de de de de		the H.	the the	F. 4	ELLOW 08 S.	S, H LIB	ELFEN ERTY	$egin{array}{c} ext{BEIN} \ ext{STREE} \end{array}$	& NEWN. T, CEN	AM FUNE TREVILI	RAL E, 1	HOME, P.A. D 21617	
8760,	The law requires that the death certificate be executed X A A page 2 should be detached for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	cause on each line.	nce of):	ion						e 4	Approximate Interval Between Onset and Death	
P.O. Box 6	the death certifice y the ettending pt iched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ √6 9 □ Unknown	: If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3	Ectopic pro					23d. Dat Mo		very Day Year	
ds, P	uires that the de signed by the e Id be detached f	ρ	Part II. Other significant conditions control	ibuting to death but not resulting	ing in the ur	derlying c	ause give	in in Part I.		23e. Did tob	_/		the cause of death?	
900	as been si 2 should	Completed	3 Hapertin	un		6				24a. Was ar	24b. \	Vere aut	opsy lindings available ompletion of cause of	_
č	isicien: The law s certificate has t lirector, page 2 s	Com								perform	ied?	leath?	2□ No	
Vita	icien: certific rector	Be	25. Was case referred to medical examiner?	spital:			Othe	- 1	-	heck only on				
Division of Vital Records,	ding Phy n. After this funeral c	ation; To	1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	1 Inpatient 2 El	R/Outpatien 8b. Time of Injury		8c. Injury Work	4 La Taurs	28d		nce 6 ⊡Oth w injury occurr		ify)	
Divis	or At Itter of Direction by	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, larm, stre	eet, factory	r, office		281.	Location (Sti City or Town		er or Ru	ral Route Number,	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical Examine one)	cian: To the best of my knowler: On the basis of examination and manner stated.		estigation,	in my op	inion, death		at the time, da	ite and place,	and due	to the cause(s)	
	To 1 To 1	Σ	29b. Signature and title of certifier	m D			License	- ~		25	od. Date signed	Month	, Day, Year)	
			> 144. Wum	,"W.	n-1 7	J. J.	y U	313			11/81	20		_
			30. Name and address of person who com	His Was	hugh	fon 7	fere.	, Che	sterl	Ewn	,mo	21	620	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re da	Si i								

			1 - For State Registrer	State of N	/larylan		artmen tificat					Reg. No.	006		
	Physicia	an	Decedent's Name (First, Middle, Last James Edward Decedents)								2. Date of De. Month	Day	Year	3. Time o	
	/Medic	al	4a. Facility Name (If not institution, give		(r)		4h City.	Town, or	Location of		July	13,	2006 unty of Death	11:30) a "
	Examin	er	1444 Grandview D		-,				Arno				Anne A	runde]	L
	Funeral		Social Security Number 6. S	9x 7. /		last birthday)	If Under	1 Year Days	If Under Hours		8. Date of Bin (Month, Da	th v. Year)	9. Birth	olace (State ontry)	or Foreign
15.0	Director		210-30-7244	X M 2□F	60	Yrs.	IVIOITUIS	Days	110010		Jan. 1				
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	ity Limits
	Maryl -f sho	tor	MD Anne Ai	rundel			P	rnol	.d					1 🗌 Yes	2 X No
	h the	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cou	ntry?	
	23a c	raiD	1444 Grandview Dr	rive				210					USA		
	tems	unei	11. Marital Status	12. Was Deceder Armed Force	s?	.S. 13.	Was Dece f Yes, spe	dent of Hi cify Cubai	spanic Ori n, Mexicar	igin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	- 14.	Race - Ameri Black, White,	etc.	
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 [If Yes, Give Year or Date:			1 🗆 Yes	2 X No	Specify:			Spi	ecify:	White	
21215-0036	2 hou		15. Decedent's Ed	ucation		16a. Dece	dent's Usu	al Occupa	ation during mos	t of working		16b. Kind	of Business/In	dustry	
215	thin 7 e.	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4c	or 5+)	life.	DO NOT u	se retired,)	I OF WORKIN	9				
2	led wi		12				Carp	et L		or's Namo	(First, Middle,	Maiden Su		-Emplo	yed
and	otal H ad oti	Be	17. Father's Name (First, Middle, Last) Frank Doyle							rry I		Maidell Sul	name,		
Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. is marked other than "natural", or items 23s or 28s-f show aumatic event, the Madisal Examinat must be notified at	은	19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailii	ng Address	(Street a			Route Numb	er, City or To	wn, State, Zij	Code)	
2	교육등		Lisa Marie Dring	g/Daughte	r	7748	8 Wes	t Sho	ore R	Road,	Pasade	ena, M	2112	22	•
altimore,			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from Sta		Place of Dispo emetery, crea	nsition (Name	me of other place	Θ)		ate 1 4		on - City or T		
Ĕ	Pages tment of tent: If it		4 □Donation 5 □Other (Specify)	M	etro C			i	•	14, 2006	Ва	ltimor	e, MD	
Bal	permit. Page Department of Importent: If any injury or once.		21. Signature of Fureral Service Licen	500	ani	B	arran	CO &	s of Facilit Sons	, P.E	A. Seve	erna Pa	ark Fu	neral	Home
			23a. Bart1. Enler the disease, or comp	olica mus that caus	sed the deat	h. Do not ent	er the mod	V R	<u>l TCN1</u> g, such as	e HW	y Seve	erna Pa rrest,	ark, M	Approxima	te
	Physician		thock, or heart failure. List only/o	one cause on each	ine.	. 1	1 4							Interval Be Onset and	
	/Medical	1	disease or condition resulting in death)	Pu	as a conseq	+1	1								
	Examiner		Sequentially list conditions.	b		(<i></i>							>34	ears
	e sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence of):								•	
	s be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or	as a conseq	uence of):									
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	icai		d											
68	tificat ng phy as th	Aedi	IE ECAMI E												
Вох	eath certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birth	2 Feta	Ideath 3[Ectopic p					23d	Date of deliv	-	Year
0	the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□ Unknowr		leath 5L	Other (s)	pecify)						,	
٥.	res that the de signed by the a be detached f	y Ph	Part II. Other significant conditions co	ontributing to death	but not res	ulting in the u	nderlying	cause give	en in Part I	l.	23e. Did t	obacco use	contribute to t	he cause of	death?
Records,	aures n sign	ed by									1 🗆	Yes 2□N	lo 3 🗆 Pro	bably 4	Unknown
000	aw requira as been si 2 should l	Completed									24a. Was		4b. Were auto	opsy findings	
	The lay ate has page 2	Com										20No	death? 1 ☐ Yes	2□No	
Vita	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Othe	00		(Check only	опе)			
ō	ding Physician: The Ih. After this certificate hatfuneral director, page	. To	1 Yes 2 No	28a. Date of I	njury	ER/Outpatier 28b. Time o		28c. Injury Work	4 190	ursing Hon	ne 5 Resi		Other (Speci curred	fy)	
lon	th. : Afte	atlor	1 □Natural 5 □ Pending 2 □ Accident investigation	(Month,	Day Year)	Injury	м		k? Yes 2□	No					
Division of	or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of	Injury - At h	ome, farm, st	reet, factor	y, office		2	28f. Location (umber or Rur	al Route Nur	nber,
ō	itel or A														
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	edical	29a. Certifier (Check only one) Certifying Ph 2 Medical Exam	ysicien: To the be niner: On the basis and manner	s of examina										s)
	within 7 To the	Med	29b. Signature and title of certifier	and manner	otatod.		29	c. License	e number			29d. Date s	igned (Month,	Day, Year)	
	->=0		1 (11/16)	MAN	2			Bms	78 71	7,		6	7/19	1/200	6
			30. Name and address of person who	completed cause	of death (Iter	n 23a) (Type,	Drunt)				(21		021	401
	The Marie Marie	Ĺ	31. Date filed (Month, Day, Year)	11 laxted	J/YI) istrar's Signa	JOO.	11/6	edic	alt	arki	eay S	uite,		Hnna	polis
	Sta Registi			UUO 32 HOG	Land Signi	K A	anth.	9			,				

			For State Registrar	State of Ma	-	partment of Certificate of		F	Reg. No UUD	24426
40,000	Physicia		1. Decedent's Name (First, Middle, Las Helen B	Downs				July 18		9:30 P M
	/Medic Examin	-cul	4a. Facility Name (If not institution, give Solomons Nursing	street and number) Center			or Location of De OMONS	ath	4c. County of Death	1
	Funeral Director		579-09-9899	7. Age	(In yrs. last birtho	Months Days		n (Month, Day	9. Birth y, <i>Year)</i> 29 1912Virg	nplace (State or Foreign untry) yinia
	Aaryland I show	ō	Usual Residence of Decedent 10a. State Virginia Tairfax		10c. City, Town o					10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	with the h	Direct	10e. Street and Number 8302 Private Lane	l		10f. Zip Code 22003	3		10g. Citizen of What Co United Stat	
36	be filed within 72 hours after death with the Maryland rial Hygiene. ed other than "natural", or items 23e or 28e-f show event, the Medical Exammer must be exitted at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ⅓ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1Yes _ 2\overline{O} N If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cu 1 Yes 2 No	ban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White Specify: who	e, etc.
21215-0036	within 72 hou ene. than "natura he Medical E	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)		(C li	ecedent's Usual Occi Bive kind of work don- fe. DO NOT use retir Okkeeper	ipation a during most of wed)	vorking	16b. Kind of Business/	ndustry
land 2	hould be filed within id Mental Hygiene. marked other than 'matic event, the Mental Hygiene.	To Be Co	17. Father's Name (First, Middle, Last) Roy Earl Baumbac	1			18. Mother's N Mabel	ame (First, Middle, Elizabe		
Maryland	12 sh h and 7 is m traum	-	19a. Informant's Name/Relationship (7) Ann D. Thomas— dat		7				er, City or Town, State, 2 Virginia 22	
Baltimore,	00		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. Place of D cemetery, Nationa	isposition (Name of crematory or other pi 1 Memoria	July 2	24 ^{Date} 2006	20c. Location - City or Falls Churc	
Balti	permit. Pag Department Important: i sny injury o once.		21. Signature of Funeral Service Licen	500	,	22. Name and Add	•		uneral Home Republic MD	
2	Physician /Medical		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Covel	the death. Do not e.	enter the mode of dy	ring, such as card	iac or respiratory ar	rrest,	Approximate Interval Between Onset and Death
8760,	Examiner	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Dad to (or as a	a consequence of)					
.O. Box 68	ne death certific the attending pl hed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ≥ ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal death	3 □ Ectopic pregnan 5 □ Other (specify)	су		23d. Date of deli Month	very Day Year
٥	iuires that the signed by ald be detacted	by	Part II. Other significent conditions of	ontributing to death bu	it not resulting in t	ne underlying cause ç	oven in Part I.		obacco use contribute to Yes 2⊠No 3 ☐ Pri	the cause of death?
I Records,	The law requir ate has been si page 2 should	Completed							an 24b. Were au prior to death? 1 \(\begin{array}{c} 22\text{No} \end{array}	topsy findings available completion of cause of
Vital	Physician: The this certificate har all director, page	Be	25. Was case reterred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2□ER/Outo	atient 3 DOA		Death (Check only o	one) dence 6 Other (Spec	nt/)
ō	fune	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. Tir	ne of 28c. In			how injury occurred	, , , , , , , , , , , , , , , , , , ,
Division	Dir	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At home, farn c. (Specily)	n, street, factory, offic	9	28f. Location (S City or Tox	Street and Number or Ru wn, State)	iral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (examination and/				cause(s) and manner as date and place, and due	
	Within To th comp	Me	29b. Signature and title of certifier	110		24	7670		29d. Date signed (Monti	/
7			30. Name and address of person who	mpleted cause of de	eath (Item 23a) (T	ype, Print)	, 7	- 0 (0 - 1	July 19,	2016
	6		DR DRUID 3 31. Date filed (Month, Day, Year)	TORD 1	S Signature	HOSPK	0 40	uce wed	wick in	0 300 38
A STATE OF	Sta Regist	ate rar	JUL 2	0 2006	Brever A	* Sparke				

State of Maryland / Department of Health and Mental Hygiene State Registra AVEND#20b, openFH, 7/20/06, BMW, MoCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician EDBERG** 4:15 P M ELEANOR ALICE 15 2006 JULY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ELLICOTT CITY MORNINGSIDE HOUSE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 ☐ M 2 🖾 F 82 Yrs 1/4/1924 ILLINOIS Director 348-16-3104 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show The Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MARYLAND HOWARD CLARKSVILLE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 21029 U.S.A. or itema 23a 13725 PASTURE GREEN Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: WHITE Specify: Completed by 3 → Widowed 4 Divorced "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HEALTHCARE NURSE event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f Depertment of Heelth and Mental P Important: If Item 27 is marked of any injury or other traumatic even ELENORA BIRNEY STEWART ٩ JOHN LEONARD BRILL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. tnformant's Name/Relationship (Type, Print) 13725 PASTURE GREEN, CLARKSVILLE, MARYLAND 21029 BECKY HUMPHREY/DAUGHTER 20b. Place of Disposition (Name of 7-24-06ate 20c. Location - City or Town, State 20a. Method of Disposition Fort Lincoln Ceneury of other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT 10 YEARS **Physician** /Medical Due to (or as a consequence of): Examiner 3 YEARS BREAST CANCER squartilly list can tions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine the attending physicien and hed for use as the burial-transit thet the death certificate be executed 10 YEARS HYPERCHOLESTEROLEMIA resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. 10 YEARS HYPOTHYROIDISM Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown MACULAR DEGENERATION Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? s certificate blirector, page 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No of Vital Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 🖾 No 1 Inpatient 3 DOA ŧ ۴ 2 ER/Outpatient this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; Injury Division 1 Natural 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide ō e Hospitel on 24 hours ef 1🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number JULY 17, 2006 D0044513 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANG-KYUNE LEE, M.D., 15201 SHADY GROVE ROAD #202, ROCKVILLE, MARYLAND 20850 32. Registrar's Siggature 31. Date filed (Month, Day, Year) State JUL 2 0 2006 Registrar

			For State Registrar		Maryland / Dep <i>Ce</i>	artment of F		F	lag. No U U	6 24428
	Physici	an	1. Decedent's Name (First, Mi	Gaither				2. Date of Dea Month	Day	Year 8 P M
	/Medic Examin		4a. Facility Name (If not institu				r Location of Death		4c. County o	
	Funeral		Bradford Oa 5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday,	If Under 1 Year	nton If Under 24 Hrs.	8. Date of Birt (Month, Day		. G . 9. Birthplace (State or Foreign
9	Director		251-78-5722	XXM 2□F	60 Yrs.	Months Days	Hours Min.	9-23	3-45	S.C.
	ow ot		Usual Residence of Decedent 10a. State 10b. Cou		10c. City, Town or L	ocation				10d. Inside City Limits
	ith the Marylan or 28a-1 show se notified at	Director		P.G.	Clint					1★Yes 2 No
	with th		10e. Street and Number 7520 Suri	ratts Road		10f. Zip Code			10g. Citizen of W U.S	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene liem 27 is marked other than "natural", or Itams 23s or 28s-1 show other traumatic event, the Medical Examinational be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ M 3 ☑ Widowed 4 □ Divor	If Vas Give	No	Was Decedent of Hif Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	Black	- American Indian, k, White, etc. Black
21215-0036	rithin 72 hou ne. han *natura s Medical E	Completed	15. Dece	dent's Education ghest grade completed)	16a. Dece (Give life.	dent's Usual Occup s kind of work done DO NOT use retired	during most of wor d)	king	16b. Kind of Bus	Employed
d 2.	filed v Hygle other t ant, th	Be Co	12th 17. Father's Name (First, Midd	dle, Last)	»	Oliberae		ne (First, Middle,	Maiden Sumame	
Maryland	should be filed within and Mental Hyglene. s marked other than "umatic evant, the Mes	To B	Willie (e Duren		
Mar	d 2 sho th and th and 7 is m traum		19a. Informant's Name/Relati			ng Address (Street 01 Howa:			r, City or Town, S 20020	State, Zip Code)
	is 1 and 2 st of Health and item 27 Is r other traur		20a. Method of Disposition		20b. Place of Disp			Date		City or Town, State
Saltimore,	permit. Pages 1 au Department of Hea Important: If item any Injury or othe once.		`4 ☐Donation 5 ☐ Othe		PTHCOTH	Mem. Co		1/06	Suitla	nd, Md.
A <u>E</u>	permit. Pa Departmen Important: any Injury once.		21. Signature of Funeral Services		A 3	2. Name and Addre The Howard Addre 814 Ups	DEA OF	William	s Fun.	Svc.
	Physician /Medical		23a. P. 11. Enter the disease slock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	a, or complications that cau List only one cause on eac a.	sed the death. Do not enth line. Here were the second of	iter the mode of Sir	Old On	or respira ory ar	DIEM?	Approximate Interval Between Onset and Death
8760,	eate be executed by social and into burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequence of):					
P.O. Box 68	aath certific attending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	I LIVE DIN	h 2 ☐ Fetal death 3 int at time of death 5 i	□Ectopic pregnanc	у		23d. Date Mon	a of delivery tth Day Year
	n requires that the debeen signed by the should be detached	by	Part II. Other significant con	ditions contributing to dea	th but not resulting in the	underlying cause giv	ven in Part I.			ibute to the cause of death? 3 ☐ Probably 4 至 Unknown
I Reco	The lay ate has page 2	Completed						24a. Was autop perfo 1 Yes	an 24b. W sy rmed? d XC No 1	Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2☐ No
Division of Vital Records,	To the Hospitel or Attanding Physician: within 24 hours after death. To the Funerel Director; After this certific completely filled in by the funeral director,	atlon: To Be	2 LI Accident	Hospital: 1 Inp 28a. Date of (Month) restigation		of 28c. Inju	ner: 4 Phing H		ne) dence 6 □Othe now injury occurre	1-177
Divis	itel or Atta	Certification:	4 ☐ Homicide de		f Injury - At home, farm, s g, etc. <i>(Specify)</i>			City or Tox	m, State)	er or Rural Route Number,
	Hosp 24 hou Fune Hely fil	edical		ifying Physician: To the b ical Examiner: On the bas and manne	is of examination and/or i					
	To the To the	Me	29b. Signature and title of ce	rtifier		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
	V		30. Name and address of per	tan on	of death (Item 23a) (Type	Print) Frank	M. (Ryan,	M.P. a	mhugh	Was 20149
	Sta Regist	ate rar	31. Date filed (Month, Day, Y	(ear) 32 Re	gistrar's Signature	ali				

06-05300 Ellis M. Gray Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 21, 2006 1340 hrs Medical Examiner Ellis Morrell Gray 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Washington 3379 Harpers Ferry Road Sharpsburg 5 Social Security Number 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Months Days Hours Director 1[X]M 2 08/31/1925 215-20-7712 80 Mary Land Usual Residence of Decedent any 10a State 10c. City, Town or Location 10d Inside City Limits permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "unatural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. Yes 2 X No Sharpsburg 1 10f. Zip Code Mary Land Washington Director 10e. Street and Number 10g. Citizen of What Country? 3379 Harpers Ferry Rd. 21782 USA Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married Yes Divorced If Yes, Give Year 3 X Widowed Yes 2 XXNo specify: Specify: White þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ltimore, MD 21215-0036 Assembler Refrigeration Manufacturer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Ellsworth Morrell Martha Louise Ebersole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Diane B. Harrell - niece 18809 Burnside Bridge rd. Sharpsburg, MD 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State crematory or other place) Mt. July 25,2006 View Cemetery Sharpsburg, Donation 5 Other Sp Maryland Osborne Funerally Home, P.A. ignature of Funeral 425 S. Conococheague St. Williamsport, MD 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical attending physician a UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day I ive birth Fetal death Month Year Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 V Unknown Diabetes Mellitus Completed 24b Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? To the Hospital or Attending Physician: The law performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other₄ examiner? Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene ဥ 1 🗸 Yes No Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: ✓ Natural 1 Yes 2 No Pending the Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined within 24 hours a (Specify) 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 22, 2006 O.C.M.E. ame and address of person who ed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 3H-3 31. Date filed (Month, Day, Year) 32 Rasistrar's Signature State 4 2006 Registrar

DHMH 17 Rev 1/2001 OCME 2006

			For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of F rtificate of			giene 200	6 24430
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day Yee	3. Time of Death
	Physici /Medic		TONYA DEE GLENN					July	19 200	
	Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, o	Location of Death	,	4c. County of D	
			PENINSULA REGION				3441864K			OMICO
	Funeral Director		220-92-9978	7. Age	(In yrs. last birthday) 27 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 10/30/1	y, _{Year)} 9.1 1978 Ma	Birthplace (State or Foreign Country) ryland
	pur A		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	aho	ö	MD Wicomico		Willards					1 ☐ Yes 2X No
	the A	ect	10e. Street and Number		WIIIAI	10f. Zip Code			10g. Citizen of What	Country?
	with the or	<u></u>	35767 Old Ocean Cit	Ty Poad		21874			USA	
	leeth	era		12. Was Decedent E	ver in U.S. 13.		ispanic Origin? (Sp	ecify Yes or No-		mencan Indian,
36	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avant, the Madical Examinar must be notilised at	by Funeral Director	1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	,	If Yes, specify Cuba 1 ☐ Yes 2 X No	sn, Mexican, Puerto Specify:	Rican, etc.)	Black, W Specify:	thite, etc. white
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힏	al Hygid I other Ivant, II	Be (17. Father's Name (First, Middle, Last)						Maiden Sumame)	
yla	should be nd Mental marked c	2	Calvin Earl Carper	nter			Ruth Fra	ancis Ru	ıark	
Maryland	2 she and le m	- 1	19a. Informant's Name/Relationship (Typ	ре, Print)					er, City or Town, Stat	
	1 and 2 Health tam 27		Jonathan Glenn (hu	usband)	35767 (20b. Place of Dispo			llards, M	aryland 218	
ore	ges 1 t of H if Its or ot		20a. Method of Disposition 1	emoval from State	cemetery, crei	matory or other plac	(8)		20c. Location - City	
Ë	Pa tmen tant:		4 □ Donation 5 □ Other (Specify)		Girdletree .					e, Maryland
Baltimore,	permit. Pages. Depertment of H Important; if Its any injury or of		21. Signature of Funeral Service License	Dean			uneral Ho Ave., Po		A. City, MD	21851
			23a. Part1. Enter the disease, or complice shock, or heert failure. List only on	cations that caused to e cause on each line	he death. Do not ent	ter the mode of dyir	ig, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	neta	statu	Nm Cn	rull Cul	1 cm	in la	Onset and Death
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	pa is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	and -tran	хаш	that initieted events cresulting in death) Last	Due to (or as a	consequence of):					
8760,	cate be executed physicien and the burial-transit	aiE	l l							
387		dical	d							
×	certif Iding Ise a:	√Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o					23d. Date of	delivery
Вох	res that the death certifi igned by the attending be detached for use as	by Physician/M	in the past 12 months?	1 ☐Live birth 2 4 ☐ Pregnant at t		Ectopic pregnancy Other (specify)			Month	Day Year
o.	the c	Jysi	9 Unknown	9□ Unknown						
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æ	: The law cete has l , page 2 s	ШО							rmed2 death	to completion of cause of 1? res 2 No
ita		a)	25. Was case referred to medical				26. Place of Deat			
>	Physician: r this certific ral director,	To B	examiner?	ospital: Inpatien	t 2 ER/Outpatier	nt 3 DOA Oth	er: 4 🗌 Nursing Ho	me 5 Resid	dence 6 Other (S	(pecify)
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	urs e erai D	ပီ	2							
	To the Hospitei or Attant within 24 hours efter death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	nar: On the basis of and manner stat	my knowledge, deat examination and/or in ed.	vestigation, in my c	ne, date and place, pinion, death occur	red at the time,	cause(s) and manner date and place, and	as stated. due to the cause(s)
	To the comp	Ž	29b. Signature and life of certifier	.^^	\	29c. Licens	e number		29d. Date signed (M	onth, Day, Year)
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SA	5		30. Name and add e of poson who co				(1	Con	^ ^	mm
			JOLEPK W. O		US E.	Comen o.	er st	YATI	16 Mry	1710 21801
	Sta Registi		31. Date filed (Month, Day, Year) JUL 2 1 2	006 32. Rogistra	r's Signature	book				

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		Registrar 1. Decedent's Name (First, Middle	a (ast)			001	incate of	Dealit		2. Date of I	Reg. No	0.800	~ ~	3. Time of Death
Physic	ian		,,	T = m 1= d =						Month July	Da	200	Year	2:22 P M
_/Med		Adeline 4a. Facility Name (If not institution		lopki			4b. City, Town,	or Location o	of Death	July	16,	. County o		Z: ZZ F
Exam	ner				, o.,				or boain					7
<u> </u>		Maplewood Park 5. Social Security Number	6. Sex		. Age (In vrs.	last birthday)	Bethe		24 Hrs.	8. Date of E	Birth	lontgo		lace (State or Foreign
Funera Director		170-10-8638	1□ M :		91		Months Day	s Hours	Min.	July	Day, Year)	Cour	sylvania
		Usual Residence of Decedent								o dry	J, 1J	10 11	CITIE	<i>y</i>
ylan		10a. State 10b. County			10c. Ci	ity, Town or Lo	cation						1	0d. Inside City Limits
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h the	Director	10e. Street and Number					10f. Zip Code	. , , .			10g. C	itizen of Wi	nat Cour	ntry?
h wit	<u>a</u>	9707 Old George	etown	Road			2	0814			U.	S.A.		
deat	Funeral	11. Marital Status	12. W		ent Ever in L	J.S. 13.	Was Decedent of		igin? (Spe	cify Yes or I		14. Race		
after or lite		1 Never Married 2 Marr	ied 1	☐ Yes 2 Yes, Give	X No		1 ☐ Yes 2 [X]N			ncari, etc.)			White,	etc.
Sours Siring	l by	3 XWidowed 4 ☐ Divorced		ear or Dat			TO THE ZIM	о зр о спу:				Specify:	Wh	ite
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ed w ygier t, t	ပ္ပ			4			Home Ma					n Hon		
d ott	Be	17. Father's Name (First, Middle,	Last)							(First, Mida	le, Maide	n Sumame)	
Men Men arke	မှ	John Joyce							у Мс					
and and sum		19a. Informant's Name/Relations		•			ng Address (Stree						tate, Zip	Code)
and and ealth m 27		Patricia Warner	/Daugl	hter		-	38th St.	, N.W.	CONTRACTOR AND ADDRESS.		+		200	
S S S S S		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation	3 □Remov	al from St		Place of Dispo cemetery, crer	sition (Name of natory or other p	lace)	D	ate	20c. l	ocation - C	ity or To	wn, State
mit. Pages partment of portant: If If If If If If If If If If If If If		4 □ Donation 5 □ Other (S			Met	ropoli	tan Crem	atory	7-20	-06	Ale	xandr	ia,	Virginia
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 show ent injury department traumatic event, if a Maryland Exam our must be notified at once.		21. Signature of Funeral Service	Licensee	1/0	,		2. Name and Add		Cartes Treat	100000000000000000000000000000000000000	CONTRACTOR			
# #9E # 9		John 1-	NaU	10C		22	22 Wisco	nsin A	Ave.,	N.W.	Wasl	ningto	on,	D.C. 20007
		23a. P.m. Enter the disease, or ck, or heart failure. List	complication only one cau	ns that cau	used the dea ch line.	th. Do not ent	er the mode of dy	ing, such as	cardiac or	respiratory	arrest,			Approximate Interval Between
Physician		Imm diate Cause (Final disease or condition	C1	hroni	c Obst	ructiv	e Lung I)isease	е					Onset and Death
/Medical		resulting in death)	(a		r as a consec									
Examiner		Sequentially list conditions	b. —											
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ocute and trans	Examiner	that initiated events	c											
be exe	ĕ	resulting in death) Last		Due to (or	as a consec	quence of):								
icate be executed physicien and the burial-transit	dical		d											
artific ing p	0	IF FEMALE:												
of use	an/	23b. Was decedent pregnant in the past 12 months?			me of pregn		Ectopic pregnan	су				23d. Date Mont		nry Day Year
e dea	<u>S</u>	1 ☐ Yes 2 🔯 No		☐ Pregnar	nt at time of o	death 5	Other (specify)				-	WOUT	''	Day 16a1
at the	Physician/M	9 Unknown												
w requires that the death certifich been signed by the ettending I should be detached for use as	þ	Part II. Other significant condition	ms contribut	ting to dea	th but not res	sulting in the u	nderlying cause g	jiven in Part I.	•					ne cause of death?
w require been si should i	ted	Hypertension	· · · · · · · · · · · · · · · · · · ·							11	Yes 2	P. □ No 3	Prob	ably 4 XUnknown
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The The este h	Ю	Cachexia								pe	formed?	de	ath? Yes	
ien:	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only				
ysic nis ce dire	10	1 ☐ Yes 2 🛣 No	Hospit	al: 1 🗆 Inp	oatient 2	ER/Outpatier	t 3 DOA	ther: 4 🔯 Nu	ırsing Hon	ne 5∐Re	sidence	6 Other	(Specify	1)
nera		27. Manner of Death 1 X Natural 5 ☐ Pendin		a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28c. Inj	ury at ork?	2	8d. Describ	e how inju	ry occurre	1	
tending leath. tor: Afte the fune	atte	2 ☐ Accident investig	gation				M 1[∃Yes 2 □	No					
r Att	₽	3 Surcide 6 Could a 4 Homicide determ		e. Place o	f Injury - At h	nome, farm, str	eet, factory, office	Ð	2		(Street a		or Rura	l Route Number,
rs aft	Certification:					-								
hou uner	edical	29a. Certifier 1 X Certifyin (Check only 2 Medical	g Physician	n: To the b	est of my kn	owledge, deatl	n occurred at the vestigation, in my	time, date an	d place, a	ind due to th	e cause(s	s) and man	ner as st	ated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledi	one)	a	ind manne	r stated.				Jugarie					
Son Son	Σ	29b. Signature and title of certifie	r	1/			29c. Lice	nse number			29d. Da	ate signed	(Month,	Day, Year)
15		1/ (erly	21	Ve	Mer	me	en I	35791			July	19,	200	6
1		30. Name and address of person											_	
		Merlyn K. Vemu		7			Ave. Sil	ver Sp	ring	, Mary	land	2090	2	<u> </u>
S Regis	tate trar	31. Date filed (Month, Day, Year)	2006	32. Reg	gistrar's Sign	H. Do	arte							

	1 - State of Maryland / Dep	artment of Health and Mertificate of Death	ental Hygiene Reg. No. 2006 21	,432
Physician	Decedent's Name (First, Middle, Last) Mary Hartzfeld Haugh		2. Date of Death Month Day Year TULLY 22 200 C #4	e of Death
/Medical Examiner	4a. Facility Name (If not institution, give street and number) Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Hagerstown If Under 1 Year If Under 24 Hrs.	4c. County of Death Washington 8. Date of Birth 9. Birthplace (Sta	to as Fassium
Funeral Director	214-09-9947 1□ M 2M F 86 Yrs. Usual Residence of Decedent	Months Days Hours Min.	Dec 28, 1919 Berkley WV	Sprin
Baltimore, Maryland 21215-0036 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28s-1 show want highry or other traumatic event, The Medical Examinar must be recitified at ance. To Be Completed by Funeral Director	Maryland Washington Hagerst 10e. Street and Number 55 E. Washington St. Apt. 610 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Never Married 2 □ Married 11. Yes 2 □ No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Education (Specify only highest grade completed) 17. Father's Name (First, Middle, Last) Calvin Hovermale 19a. Informant's Name/Relationship (Type, Print) Mary L. Souders/Niece 118 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Own, Maryland 10f. Zip Code 21740 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 Yes 2 No Specify: Ident's Usual Occupation a kind of work done during most of working DO NOT use retired) 18. Mother's Name Gertie Ing Address (Street and Number or Rura Franklin St. Ha osition (Name of imatory or other place)	10g. Citizen of What Country? United States City Yes or No- Citizen of What Country? United States 14. Race - American Indian Black, White, etc. Specify: White 16b. Kind of Business/Industry Self Employed (First, Middle, Maiden Sumame) Culp Hovermale Wear Route Number, City or Town, State, Zip Code) ancock, MD 21750 ate 20c. Location - City or Town, State 5,2006 Hagerstown, MI	d ver
death certificate be executed to entificate be executed to entificate be executed to entificate by the entire of t	23a. Part1. Enter the disease, or complications that daused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ster the mode of dying, such as cardiac o	Interval	nate
The law requires that the detection is the law requires that the detection is the law requires that the detection is the law requirement is the law requirement.	in the past 12 months? 1 Yes 2 SNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the significant conditions.	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of the cause	□Unknown gs available
IVISION OF r Attending Physicar death. Irector: After this by the funeral di	25. Was case referred to medical examiner? 1	of 28c. Injury at 2 Work? M 1 Yes 2 No	Check only one 10 5 Residence 6 Other (Specify) 11 8d. Describe how injury occurred 12 18f. Location (Street and Number or Rural Route Nicity or Town, State)	umber,
To the Hospital or within 24 hours af To the Funaral D completely filled in Medical Cer	29a. Certifier (Check only one) 29b. Signature and title of certifier May E May E	th occurred at the time, date and place, a evestigation, in my opinion, death occurred 29c. License number	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause 29d. Date signed (Month, Day, Year	
ろ H -し State Registrar	30. Name and address of person, who completed cause of death (Item 23a) (Type WARY & WONE, WO). 35 4 31. Date filed (Month, Day, Year) 32. Registrar's Signature		lagerstown, mD 2	1740

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

				State of Ivia	aryiano	•	tificate o		wientai myg	P P	06	24433
	D		1. Decedent's Name (First, Middle, Last)						2. Date of Dee Month	th Dey	Year	3. Time of Death
-	Physicia /Medic		Joseph Franklin H	OSE						2, 2006)	2:55 p.m.
}	Examin		4a Fecility Neme (If not institution, give s						Locetion of Death	4c. County		
		q	Julia Manor Nursi				If Daylor 4 Va	Hagers			shing	
	Funeral Director		219-03-2023	M 2□ F	e (In yrs. k	est birthday) Yrs.	If Under 1 Yes Months Day			1 ^{Yeer)} 1919	9. Birthp Coun Mar	lace (State or Foreign cyland
	AKC #		Usuel Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation				1	0d. Inside City Limits
	Mary If sh	ğ	Maryland Washing	ton		Hager	stown					1 ☐ Yes 2 2 No
	with the	Direc	10e. Street and Number 16909 Harbinger C:	ircle			10f. Zip Code	21740	1	0g. Citizen of V	What Coun	try?
020	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exertified mat be notified at once.	by Funeral Director		2. Was Decedent Armed Forces? 1 Yes 2 1 h If Yes, Give Year or Dates:			Vas Decedent o Yes, specify Co ☐ Yes 2⊠ N	f Hispanic Origin? (uban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Rac Blac	e - Americ ck, White, www.whi	etc.
Maryland 21215-0020	ithin 72 ho 16. Nan "natur Nadical	Completed by	15. Decedent's Educ (Specify only highest grede Elementary/Secondary (0-12)	College (1-4or 5	+)	(Give I life. D		upation ne during most of wo red)	orking	16b. Kind of Bu		
2	Hygier Hygier Her th	S	10 17. Father's Neme (First, Middle, Lest)	0		sal	esman	18 Mother's Na	ame (First, Middle, I	auto de		snip
au	d be f	o Be	Joseph Franklin Ho	nse					K. Shiff		,6,	
ar _Z	Shoul nd Me mark imati	ဥ	19a. Informant's Name/Relationship (Typ		ther-	19b. Mailin	g Address (Stre		Rural Route Number		State, Zip	Code)
	end 2 saith e n 27 ia		Russell E. Hartle,		law .	11408	3 Longv	lew Dr.,	Hagerstow	n, Md.	21740	0
Baltimore,	Pages 1 lent of Hi nt: if Iten ry or oth		20a. Method of Disposition 1 □ Burial 2X□ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	emoval from State			sition (Name of patory or other p wn Crem			20c. Location - Hagers		wn, State , Maryland
Balti	permit. Depertrainmonts any Inju		21. Signature of Euroral Service License	non	~ ~ ~	//	Name and Add	•	MINNICH d., Hager			
100		\exists	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	vations that caused	the death	. Do not ente	r the mode of d	ying, such as cardia	ac or respiratory arr	est,	1	Approximate Interval Between
	Physician /Medical		Immediete Cause (Final disease or condition								1	Onset and Death
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60,	tificete be executed g physician end es the bunel-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events		Due to (or	as e consequ	ience or):					
ς 68760,	ortificate ing phys e es the		resulting in death) Last		Due to (or	as a consequ	ience of):				į	
Вох	ath ce ttendi or us	Physician/	d									
	the a	ysic	Part II. Other significant conditions cont	ributing to death bu	it not resul	lting in the un	derlying cause	given in Part I.	23b. Did to	bacco use cor	ntribute to	the cause of death?
s, P.O	gned by	by Ph	DKM	entia					1 🗆 Y	ee 2□ No	3 ☐ Prob	pably 4 □/Unknown
of Vital Records,	been s	Completed							24a. Was a perform	n autopsy ned?	ava	ere autopsy findings ailable prior to mpletion of cause death?
Œ.	The I	E O							1DY	8 2/0 No	10]Yes 2□ No
/ita	clan: entific actor,	8	25. Was case referred to medical examiner?				- 10		eath (Check only on	e)		
on of \	ing Physic After this c funeral dire	lon: To	27. Menner of Death 1 Natural 5 Pending	ospital: 1 ☐ Inpatie 28a. Date of Injur (Month, De)	у	ER/Outpatient 28b. Time of Injury	28c. In		Home 5 Reside			′)
Division	To the Hospital or Attanding Physician: The law within 24 hours efter death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injubulding, etc	ıry - At hor (Specify)	me, farm, stre			28f. Location (St City or Town		er or Rura	l Route Number,
_	Hospita 24 hours Reneral letely filled	edical C	29a. Certifier (Check only one) 1 Certifying Phyei 2 Medical Examin	cian: To the best of er: On the basis of and manner sta	examinati	rledge, deeth on end/or inv	occurred at the estigation, in my	time, date end place opinion, death occ	e, and due to the courred et the time, d	ause(s) and ma ate and place, a	nner as stand due to	ated. the cause(s)
	Vithin To the	Me	29b. Signature end title of certifier	11				co396)	9d. Date signed		Day, Yeer) O G
٠.	11 ^		30. Name and address of person who cor	npleted cause of d		23e) (Type, F	Print) 112	-6 000	al Lour	+	, [
9	H-O Stat	e	31. Date filed (Month, Day, Year)	32. Registre		ure	t	tagerst or	Ja M	0 217	40	
	Registra		JUL 25 200	06		A A	a. 1. 2					

DHMH 16 Rev 6/95

7. Age (In yrs. last birthday)

89

Certificate of Death

GIEN BUINI

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

213-28-6033

Usual Residence of Decedent

KOSLOWSKI

Baltimore washington medical Center

1 ☐ M 2 🗹 F

6. Sex

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

Examiner

Funeral

Director

State of Maryland / Department of Health and Mental Hygiene 2. Date of Death 3. Time of Death Month Day 7:30 PM 2006 JU14 6 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year If Under 24 Hrs.
Months Days Hours Main Arundel Anne 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 24, 1917 Maryland 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? Race - American Indian, Black, White, etc. White Specify: 16b. Kind of Business/Industry Home 18. Mother's Name (First, Middle, Maiden Surname) Leanora Makawski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Harborside Drive Apt. A Joppatowne, MD 21085 July 20, 20c. Location · City or Town, State 2006 Glen Burnie, MD Severna Park Funeral H Severna Park, MD 21146 Home Approximate Interval Between 12 hours Y-20-5 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28I. Location (Street and Number or Rural Route Number, City or Town, State) the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number
000224 83 29d. Date signed (Month, Day, Year) July 16, 2006

State Registrar

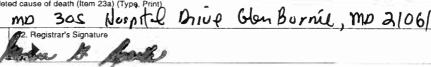
Medical

29a. Certifier (Check only

29b. Signature and till of ce

31. Date filed (Month, Day, Year) JUL 1 9 2006

STUART JACUAS



and manner stated.

30. Name and address of polion who completed cause of death (Item 23a) (Type, Print)

To the

		1 - For State of Maryland / Department	artment of Health and N rtificate of Death	Mental Hygie	4000	24436
Dhw	cicio	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	siciar edica	BLANCHE ELIZABETH LEWIS			13 2006	11:00 A ^M
Exa	mine		4b. City, Town, or Location of Death		4c. County of Deat	
		3301 Hewitt Avenue, Apt #303 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Silver Spring If Under 1 Year If Under 24 Hrs.	9 Date of Righ	Montgome	
Fune: Direct		230.56.0950 1□M 2\sqrt{F} 62 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) Co	hplace (State or Foreign untry)
D		Usual Residence of Decedent		000. 9,	1945 VII	ginia
urylan show	١.	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits
Ba-f		Maryland Montgomery Silver Sp				1 ☐ Yes 2 🔀 No
with th	È	10e. Street and Number	10f. Zip Code		. Citizen of What Co	untry?
death with the Maryland ms 23s or 28s-f show	101	3301 Hewitt Avenue, Apt #303 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20906		U.S.A.	for today
fter d riterr		Th. Marinal Status Armed Forces? 1 ☑ Never Married 2 ☑ Married 1 ☑ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
ureli, or	Ì	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2☑ No Specify:		Specify: B1	ack
72 hc 72 hc	Total Car	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ring 16	b. Kind of Business/	ndustry
vithin Ne.	1	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	9		
iled v	8		Technician	e (First, Middle, Mai	NIH	
d be file ontal Hy ced oth	å				,	
should Me mark	٤		Mary ng Address (Street and Number or Rui	Elizabeth		in Code)
Man 2 st alth and 27 is n			Box 14393, August			,p 0000)
perillinore, interfyiation 212.15-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or items 23s or 28s-f ehow any injury or other treumstic event, the Madical Examiner must be notified as	0	20a. Method of Disposition 20b. Place of Dispo	sition (Name of matory or other place)		c. Location · City or	Fown, State
Page Page nent c	D	L Dunai 2 Cremation 3 K Removal trom State	morial Cem. 07/2	1/2006 Su	ffolk. Vi	ruinia
rmit. Pages spartment of sportant: If it it it it injury or o	9	21. Signature of Funeral Service (ic risee	2. Name and Address of Facility HI	NES-RINAL	DI FUNERAL	L HOME. TNC.
0 83E5	a	1 Carrier 1	1800 New Hampshir	e Ave, Si	lver Spri	ng, MD 20904
20000		234. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Pnysicia /Medic	_	disease or condition resulting in death) a. Metastatic Lung Ca Due to (or as a consequence of):	ncer			6 Years
Examin	er					
D #	i d	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury				
icate be executed physicien and sthe burial-transit	Fyaminer	Cause (Disease or injury that initiated events resulting in death) Last				
e be ex sicien	u i	resulting in death) Last Due to (or as a consequence of):				
physicate sthe	100	d				
that the death certificated by the attending processes as	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	1000000		23d. Date of delin	
death a attar d for u	Physician/M	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Live birth 2 ☐ Fetal death 5 ☐ Fetal death	Ectopic pregnancy Other (specify)		Month Month	Day Year
the cy	ayd	9 □Unknown 9□Unknown				
ires tha signed d be del	2	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
w require been signatured is	0	Chronic Lung Disease		1 🗆 Yes	2□No 3⊠Pro	bably 4 Unknown
e law n has be	Completed	Cardiac Arrythmia		24a. Was an autopsy	24b. Were aut	opsy findings available
tanding Physician: The la leath. tor: After this certificate has the funeral director, page 2				performed	? death?	2□ No
vician: Thisician certificate	8	25. Was case referred to medical examiner?		Check only one)		
Phys al dir	P.	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien 27. Manner of Death 28a. Date of Injury 28b. Time of	The second secon			fy)
ding After fune	5	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred	
Attan er deat ector: by the	ertification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, str.		28f. Location (Stree	t and Number or Ru	al Boute Number
after Direction	110	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	tate)	arriodio rambor,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attended. To the Funeral Director: Attent his certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Polical C	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, death of the death	occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the To the	A	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	Day, Year)
5		· memens	D-33229		July19, 2	006
		30. Name and address of person who completed cause of death (Item 23a) (Type,	•		- 10-10-10	
		Ram S. Trehan, M.D., 1400 Forest Gle		5, Silver	Spring,	MD 20910
	State istrar	31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	call			

06-05111

Matthew In Woo Lee

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar		Certificate o		- Werter		, No.	75 01.1.3
Me	Physic dical Exam		1. Decedent's Name (First, Middle, L: Matthew I	n Woo	Lee			2. Date of Death Month July 16, 20	Day Year 06	3. Time of Death 1750 hrs
Name of the last			4a. Facility Name (if not institution, g Assateague Island	ive street and number)		4b. City, Town, or Assateague	Location of Death		4c. County of De Worcester	ath
	Funeral Director		350-68-1121		n yrs. last birthday) 2	If Under 1 Yea Months Day s.		_	(MM/DD/YYYY) 9. /1954 For	Birthplace (State or
	and show any nce.	ا ا	Usual Residence of Decedent 10a. State MD Montgo		City, Town or Loca Gaithe					10d. Inside City Limits 1 Yes 2 No
	the Maryl: 8a or 28a-f	Director	10e. Street and Number 12 Argosy Cir	cle		10f. Zip Code 208	78	100	g. Citizen of What C USA	
	nore, MD 21215-0036 siges 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. tte If tiem 27 is marked other than "natural", or items 23a or 28a-f show any other trannantic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 X Marrie 3 Widowed 4 Divorce	12. Was Decedent Even Armed Forces? 1 Yes, Gives Year or Dates:	No If `	as Decedent of His Yes, specify Cubar Yes 2 X No	n, Mexican, Puerto		14. Race - Am White, etc Specify:	erican Indian, Black, Asian
	1036 Aithin 72 hours ene. er than "naturi	Completed b	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)	during r	nt's Usual Occupa nost of working life eral Co	. DO NOT use ret	ired)	Constru	•
	1215-0036 I be filed within 7 ental Hygiene. arked other than vent, the Medica	Be Co	17. Father's Name (First, Middle, La: Yong Kil Lee		90 8-01032-		Ok So	e (First, Middle, Ma on Chor	1	
	ore, MD 21215-0036 is 1 and 2 should be filed within 720 Metalth and Mental Hygiene. Of tirem 27 is marked other than ner traumatic event, the Medical	1	19a. Informant's Name/Relationship Jason Lee/Brot		3340	0 Wildw	ood Roa	d Suwar		gia 30024
0	- a s = z		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Specific	y:	20b. Place of Dispo crematory or o Gate of	ther place) Heaver	n 7/2	0/06		Spring,Md
D			21. Sign true of Funeral Servic Civ	lls						CE,PA ng,Md20910
	Physician /Medical Examiner			each line. a. Drowning		the mode of dying,	such as cardiac o	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
		Ļ	or condition resulting in death) Sequentially list conditions,	Due to (or as a conseque						
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of Lighty that hilliate), events resulting in death). Last	Due to (or as a consequence. Due to (or as a consequence)				•••		
	760, feate be executed physician and the burial - transit			dAMENDED						
	68 certif	ician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 4 Pregnant at time	2 Fe	etal death 3 ther (Specify)	Ectopic pregna	ancy	23d. Date of delive	ery Day Year
	that the death certife ned by the attending detached for use as	Physi	Part II. Other significant conditions	9 Unknown	t not resulting in the	underlying cause (given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
	Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attended or the completely filled in by the funeral director, page 2 should be detended for u							1 Yes 24a. Was ar autopsy	24b. Were	robably 4 Unknown autopsy findings available b completion of cause of
	Vital Reco ysician: The law his certificate has director, page 2 s	Completed	-					perform 1 V Yes 2	ed? death	?
	Vital Rechysician: The this certificate I director, page	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 ER/Outpatien		of Death (Check Other Nursir		esidence 6 🗸 Oth	ner: Scene
	ion of V tending Phy eath or: After the	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigs		28b. Time of 1705 hrs		ry at Work? Yes 2 No	28d Describe ho Subject drow	w injury occurred ned	
	Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not determine	ot be 28e. Place of Injury	- At home, farm, stre	eet, factory, office b	building, etc.	or Town, Sta		Rural Route Number, City
	To the Hospita within 24 hours To the Funeral completely fille	dical		er: On the best of my kn and manner stated						
	19	Me	29b. Signature and title of certifier	SA.		29c. Licens O.C.			29d. Date signed <i>(N</i> July 17, 2006	fonth, Day, Year)
			30. Name and address of person wh Zabiullah Ali, M.D. Ass	o completed cause of death sistant Medical Exan		nn Street, Balt	imore, MD 21	201		
	S Regis	tate		Registrar's S	ignature	w				

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

JUL 21 2006

06-05306 Jaso

Please Type or Print in Black Indelible Ink

on Leon Line		State of Maryland / Department of 1-For State Certificate of Cert		lygiene _{Reg}	.No. 2006 2443
Physicia edical Exami	n/	1. Decedent's Name (First, Middle, Last) Jason Leon Line		2. Date of Death Month I July 21, 200	3. Time of Death
- tu		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death
		Potomac River at Dam #4 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Williamsport If Under 1 Year If Under 24Hr	s 8 Date of Birth	Washington (MM/DD/YYYY) 9. Birthplace (State or
Funeral Director		217-17-0364 1XM 2F 19 Y	Months Days Hours Mir		Eoroigo
id how any ce.		Usual Residence of Decedent 10a. State			10d. Inside City Limits 1 XYes 2 No
ith the Maryland ; 23a or 28a-f show ; notified at once.	Director	10e. Street and Number 550 N. Mulberry Street	10f Zip Code 21740	10g	i. Citizen of What Country? US
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 X Never Married 2 Married Armed Forces? If Yes 2 X No	/as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
urs after tural", o	d by F		Yes 2 X No specify: ent's Usual Occupation (Give kind of		Specify: White 6b. Kind of Business/Industry
36 in 72 ho han *na lical Ex.	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use re etrician's Appren	·	Electrical
5-00% ed withi tygiene other tl	Com	17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Ma	ilden Surname)
121 Id be fil Mental F narked event, 1	o Be	Roger Leon Line 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	Debra ng Address (Street and Number or	Ann Dobso	
MD 2 d 2 shou th and N 1 27 is n	۱٩	Roger L. Line / Father 550	N. Mulberry Str	eet, Hage	erstown, MD 21740
Ore, ges l and of Heal If iten ther tra		1 X Burial 2 Cremation 3 Removal from State crematory or o			20c. Location - City or Town, State
altim nit. Pag sartment sortant: ury or o			wn Mem. Park 07,		Hagerstown, MD Minnich Funeral Home
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	05 N. Potomac St	reet, Hag	gerstown, MD 21740
Physician /Medical		23a. Part i. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease a. Drowning	the mode of dying, such as cardiac	or respiratory arres	t, shock, or heart Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):			
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
red nsit	Examiner	events resulting in death) Last Due to (or as a consequence of): d			
e execui cian and rrial - tra	Medical	UNPENDED AMENDED			
8760, ifficate be ng physicias the buri	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregr	nancy	23d. Date of delivery Month Day Year
Box 687 e death certific the attending p	Physician/	past 12 months? 4 Pregnant at time of death 5 Unknown	Other (Specify)		
P.O. B es that the d igned by the		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		acco use contribute to the cause of death?
Is, P quires th en signe uld be d	ted by		<u>, ,</u>	1 Yes	2 No 3 Probably 4 Unknown 24b. Were autopsy findings available
e law re e has be ge 2 sho	Completed			autopsy perform 1 V Yes 2	ned? death?
al Rein Th	Be Co	25 Was case referred to medical examiner?	26.Place of Death (Check		Tes 2 No
of Vit Physic Per this c	2	1 ✓ Yes 2 No Inpatient 2 ER/Outpatie 27, Manner of Death 28a. Date of Injury 28b. Time of			esidence 6 Other Scene w injury occurred
ion C tending eath tor: Af	ation	1 Natural 5 Pending Jul 19, 2006 1830 hrs 2 ✓ Accident Investigation	1 Yes 2 ✔ No	Subject drow	ned
Division of Vital Records, urs after despiration of Notal Records urs after death ran Directors. After this certificate has been si tiled in by the funeral director, page 2 should be the funeral director, page 2 should be the funeral director.	Certification:	3 Suicide 6 Could not be determined (Specify) River	reet, factory, office building, etc.	or Town, Sta	reet and Number or Rural Route Number, City ite) er at Dam #4, Williamsport, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death by the Hospital or Attentials overlificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical C	29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investign and manner stated			
F » F »	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d Date signed (Month, Day, Year) July 22, 2006
		30. Name and address of person who completed cause of death (Item 23a)	0.0.11.2.		
5H-7		Margarita Korell MD. Assistant Medical Examiner 111	Penn Street, Baltimore, MD	21201	
S Regis	tate trar	31. Date filed (Month Day, Year) 32. Resistrar's Signature	ale		
DHMH 17 Rev 1/2	2001	ORIGIN	AL		

DHMH 17 Rev 1/2001 OCME 2006

			1 - For State Registrar	State of Maryla	ind / Dep	artment o			piene 006	2 4
			Decedent's Name (First, Middle, Last)					2. Date of Dea	th	3. Time of Death
	Physici		DORIS MARGARET	LUCHIK				JULY	21, 2006	1:15A.M.M
	/Medic Examir		4a. Facility Name (If not institution, give s			4b. City, Tow	m, or Location of D		4c. County of Deat	
1			REEDERS MEMORIAL H	OME.			BOONS	SBORO	WASH	HINGTON
	Funeral		Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Y Months Da	ear If Under 24			hplace (State or Foreign
ш	Director		201-20-6085	M 25√F 78	Yrs.	Mortus	ays Hours	FEB. 29		NNSYLVANTA
	pu ,		Usual Residence of Decedent	100	City, Town or Lo					
	the Marylar 28a-f show notified at	2	10a. State 10b. County	100.	oity, Town or Lo	cation				10d. Inside City Limits 1 1 Yes 2 □ No
	Sa-f	ctc	MARYLAND WASHING	GTON			BOONSBORC			
	with th	Director	10e. Street and Number			10f. Zip Co		1	0g. Citizen of What Co	untry?
	ath v	rai	141 SOUTH MAIN STRI				21713		U.S	
	er de	Funerai		12. Was Decedent Ever in Amed Forces?	U.S. 13.	Was Decedent If Yes, specify (of Hispanic Origin Cuban, Mexican, P	? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, Whit	
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 M2No If Yes, Give Year or Dates:		1 □ Yes 2 🔯	No Specify:		Specify:	LITTOD
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show he Medical Examinar must be notified at	ed t	15. Decedent's Educ		16a Dece	dent's Usual O	ncupation		16b. Kind of Business/	WHITE
15	in 72	Completed	(Specify only highest grade	completed)	(Give		one during most of	f working	160. Kind of Business/	industry
12	with there	E	Elementary/Secondary (0-12)	College (1-4or 5+)		110		EDK	ET ECODONIA	C MANUTURA
	Hygir Hygir Sther ent,		17. Father's Name (First, Middle, Last)			MICKINAI	18. Mother's	Name (First, Middle, i	ELECTRONI Maiden Sumame)	- MANUFAL.
a	Mental Mental arked o	To Be	PATRICK J. COYLE				MARY .1	. BACK		
Maryland	should and Men is marks aumatic	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ng Address (St			, City or Town, State, 2	Zip Code)
Ž			Joann Wagner/Daugh	rer					MARYLAND	21782
<u>a</u>	f Health frem 27 other tr		20a. Method of Disposition		Place of Dispo	sition (Name o	of		20c. Location - City or	
9	Pages nent of int: If it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			matory or other	7/	24/2006	o Tompo proper	FIFARE
Baltimore	그 문문을 .		21. Signature of Furieral Strates License		IGHWOOD 22		KY ddress of Facility	-	PITTSBURGH,	
B	permi Depa Impo eny ir		A SUSTINIA	elly À. Zimm			ral Home		National o	
			23a. Part1. +1 r lb dise or complice shock, r he rt failure. List only on	100		er the mode of	dying, such as car			Approximate
			shock, or hand failure. List only on Immediate Cause (Final	e cause on each line.			~			Interval Between Onset and Death
-	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse		mone	a			36
н	Examiner			ODde to (or as a conse	addence of).					
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a cons	equence of):					
	d d ansit	E	Cause (Disease or injury that initiated events							
Ć.	be executed sicien and burial-transit	Examiner	resulting in death) Last	Due to (or as a conse	equence of):					
760		cai	d							
	leath certificat attending phy I for use as thi									
Вох	andir use	S	23b. was decedent pregnant	3c. If yes, outcome of preg 1□Live birth 2□Fe		Ectopic prean			23d. Date of deli	very
ω.	deat e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at time of		Other (specif)			Month	Day Year
P.0	that the de ned by the a detached f	Physician/Med	9 Unknown	9□ Unknown						
S, F	es the		Part II. Other significant conditions con	tributing to death but not re	esulting in the u	nderlying cause	given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
Records,	w require been signal should b	ed	en stoge sen	enter -	rospi.	e pe	lient	1 □ Ye	es 2,⊠No 3 □ Pro	obably 4 Unknown
သို့	e law re has be je 2 sho	plet			</td <td>/</td> <td></td> <td>24a. Was a</td> <td>n 24b. Were au</td> <td>topsy findings available</td>	/		24a. Was a	n 24b. Were au	topsy findings available
œ.	The law requires that the death certifica sale has been signed by the attending ph page 2 should be detached for use as the	Completed by						— autops perform 1 ☐ Yes 2	ned? death?	completion of cause of 2 No
Vital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of	Death / Check only on	<u> </u>	2010
† <	d is	TO E	examiner?	ospital: 1 ☐ Inpatient 2 [☐ ER/Outpatier	nt 3 DOA	Other: 4 Nursin	ng Home 5 ☐ Reside	ence 6 □Other (Spec	cify)
ιof	fing Ph J. After th funeral		27. Manner of Death 1. □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		Injury at Work?	28d. Describe ho	ow injury occurred	
<u>ō</u>	tendir death. tor: Af the fu	atic	2 ☐ Accident investigation		.,.,.,		1 ☐ Yes 2 ☐ No			
Division	or Attend efter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, off	ice	28f. Location (St. City or Town	reet and Number or Ru 1, State)	ral Route Number,
	rs eff	Se								
	To the Hospital or Attending within 24 hours effer death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 12 Certifying Phys (Check only one)	ician: To the best of my keer: On the basis of examinand manner stated.	nowledge, deat nation and/or in	n occurred at the vestigation, in r	e time, date and p ny opinion, death o	lace, and due to the ca occurred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	vithin o the ompl	Me	29b. Signature and title of certifier	/		29c. Lic	cense number	2	9d. Date signed (Month	i, Day, Year)
	-> + 0	1	All I			07	2518	-	121/06	
•		1	30. Name and address of verson who col	moleted cause of death (It.	em 23a) (Tuno	Print)			/ - / -	
LKH	-3		DR. ROBERT GUEDEN	IET. 21 WYANI	DRIVE	, KEEDY	SVILLE, M	MARYLAND	301-432-22	22
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature		-			
	Registr		JUL 2 4 200	06 Breen	B. S.	who				

DHMH 17 Rev 1/2001

NAME: LUCHIK, DORIS

		•	For State Registrar		State of Ma	arylan	-			tealth a <i>Death</i>	and Me	ental Hy	giene Reg. No.	7000	2441	-
	Physici		1. Decedent's Name (First,) Cicely p	Middle, Las								2. Date of D Month July	Day		3. Time of Dea 3:00 P	th M
	/Medic Examin		4a. Facility Name (If not insti					4b. City	, Town, c	or Location of	of Death			County of Dea		
			9706 Saxon	y Roa	d			Silv	er S	pring				Mont	cgomery	
	Funeral		5. Social Security Number	6. S		e (In yrs.	last birthday)	If Unde	r 1 Year Days	If Under	24 Hrs.	8. Date of Bi (Month, D	rth	9. Bir	thplace (State or For	eign
	Director		021-38-1546	1	□ M 2 3 F 5	9	Yrs.	WOUTH	Days	Hours		May 24			ssachusett	
	P		Usual Residence of Decede												1	
	urytar show	_	10a. State 10b. Co	•			y, Town or Lo								10d. Inside City Lin	
	Ba-f	ct	Maryland Mon	ntgom	ery 	Silv	er Spr	ing							1 □ Yes 🐉 🗀	No
	death with the Maryland rme 23a or 28a-f ehow	ai Directo	10e. Street and Number 9706 Saxon	y Roa	đ			10f. Z	p Code 2091	0				izen of What C JSA	ountry?	
2-003o	n 72 hours after death with the Marylan "naturel", or Iteme 23a or 28a-f ehow kilical Examiner mant be notified at	by Funeral	11. Marital Status 1 □ Never Married 2√2 3 □ Widowed 4 □ Divo		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Was Dece f Yes, sp t ☐ Yes		Hispanic Origan, Mexican Specify:	gin? (Spec i, Puerto R	city Yes or N Rican, etc.)	0-	14. Race - Am Black, Whi Specif Whit	te, etc.	
2	"natur	Completed		edent's Ed ighest gra	fucation de completed)		16a. Deced	dent's Usi kind of w	ork done	during most	t of workin	g	16b. Ki	ind of Business	/fndustry	
V	within ene. then "	Ę	Elementary/Secondary (0-	12)	College (1-4or 5	+)				•				a		
7	Hygie ther ant,		17. Father's Name (First, Mi	ridie (ast)	5+		Mas	ter	Libr	arian	r's Name	(First, Middle		rary So	cience	
au	d be f ental l ked of	To Be	Robert J.									tersor		Jumamey		
	Shoul nd M mari	-	19a. Informant's Name/Rela	-	_		19b. Mailin	ng Addres						r Town, State,	Zip Code)	
Z	lith ar 27 le		Charles L. (**			_						MD 209		
more,	permit. Pages 1 and 2 should be filed w Department of Health and Mental hygies Important: It lem 27 is marked other it eny injury grather traumatic event, Inn once.		20a. Method of Disposition 1 ☐ Burial 2 🛣 Crema			0	lace of Dispo	natory or	other pla		July		20c. Lo	ocation - City or	Town, State	
alltil	rtmer rtant	1	4 ☐ Donation 5 ☐ Oth 21. Signature of Funeral Se			Meta	ropolita				200				Virginia	1
מ	Depa Impo eny I		Mha	Ma	Wefter	er								me Inc)]
New York	Physician /Medical Examiner		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	se, or comp List only	plications that caused one cause on each lir a. Stage 4 Due to (or as	_{Brea}	h. Do not ent	er the mo						-	Approximate Interval Between Onset and Death 18 Month	1
2870U,	ficate be executed physicien and ts the burial-transit	cal Examiner	Sequentially list conditions, I ary, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	b. Due to (or as											
.O. BOX 68	death certi e attending ed for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	fdeath 3]Ectopic ;] Other (s		у		———		23d. Date of de Month	livery Day Year	
cords, r	requires that the veen signed by th hould be detache	þ	Part II. Other significant co	nditions c	ontributing to death be	ut not res	ulting in the ur	nderlying	cause giv	ven in Part I.			tobacco u Yes 21		o the cause of death' robably 4 Unkno	
COS	aw as t	Completed										24a. Was		24b. Were a	utopsy findings availa completion of cause	able of
ב	The sete h	5										perf	ormed?	death?	2 □ No	
<u>a</u>	eriffic actor,	Be	25. Was case referred to me examiner?	edical							of Death	(Check only	one)			
_	Physicien: r this certific ral director,	2	1 ☐ Yes 2 € No		Hospital: 1 ☐ Inpatie	nt 2 🗆	ER/Outpatien	t 3 🗆 🗅	OA Ott	ner: 4 □ Nu	rsing Hom	e 5⊡x,Res	idence (6 □Other (Spe	icify)	
0 00	tending Physicien: The leath. tor: After this certificate hathe funeral director, page			ending vestigation	28a. Date of Injui (Month, Da)	Year)	28b. Time of Injury	М	28c. Injur Wor 1 🗆	yat rk? Yes 2∐t		8d. Describe	how injur	y occurred		
DIVISION	To the Hospital or Attending P. within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral.	Certification:	3 ☐ Suicide 6 ☐ C	ould not be etermined				eet, facto	ry, office		28	8f. Location (City or To	Street an wn, State	d Number or R)	ural Route Number,	
	Mospite 24 hours Funeral	edical C	29a. Certifier 1 Cer (Check only 2 Med	tifying Ph dical Exam	ysician: To the best on the basis of and manner sta	examina	wledge, death tion and/or inv	occurre vestigatio	at the tir	me, date and opinion, deat	d place, ar th occurred	nd due to the d at the time,	cause(s) date and	and manner as I place, and due	s stated. It to the cause(s)	
	o the	Mec		ertifier				29	c. Licens	se number			29d. Dat	te signed (Mon	h, Dey, Year)	
)	F 3 F 8	26	(P).	00	ula.	<	20			54378						
	15		30. Name and address of perchery! Ayles	son who	completed cause of di	eath (item	2 ^{3a)} (Type, O Univ	Print) ersi	ty B	lvd, V	Wheat	on, MI		78-06 02		
	Sta	_	31. Date filed (Month, Day,	Year)	2. Registra											
	Registr	ar	.[[] 2	II 700	5 Bearing	1%	1.3334									

			1 = For State Registrar	State of	Marylan	id / Depa <i>Cei</i>	artmei <i>rtifica</i>	nt of H <i>te of i</i>	lealth a Death	and M		giene Reg. No		06	241	+42
			Decedent's Name (First, Middle, La.	st)							2. Date of De	aath			3. Time of	Death
	Physici		Sarenia Handy Ne	TAC OM							July 1	3. Da	2006	Year	9:55	РМ
	/Medic		4a. Facility Name (If not institution, giv		er)		4b. City	, Town, or	r Location	of Death			. County	of Death	1 2 . 3 5	
	Examir	ier	Collington Nursi		/				1vi11				ince		rose	
			5. Social Security Number 6. S		Age (In vrs.	last birthday)		er 1 Year	If Under		8. Date of Bir					or Foreian
	Funeral Director			□ M 2[X F	65	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 02/20/	y, Year)		Mary	lace (State of try)	
			Usual Residence of Decedent				1	1			02/20/	1741		rialy	Tanu	
	land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside C	ity Limits
	Mary	ō	Maryland Prince	Georges	Mit	chelly	7i11e								1 □Yes	2 🛛 No
	28a	eci	10e. Street and Number	ocorges	7111	CHCIIV		ip Code				10a. Cit	izen of W	/hat Cour	ntry?	
	with a	급	925 Lake Overlook	Drive				721				USA			,	
	filed within 72 hours after death with the Maryland Hygiene. other then "natural", or fleme 23a or 28e-f show ont, the Madical Examiner must be notified at	Funeral Director		12. Was Decede	ent Ever in U	S 13 '			lispanic Ori	igin? (Spe	cify Yes or No		14 Bace	- Americ	an Indian,	
	the T	ü	11. Marital Status 1 □ Never Married 2 □ Married	Armed Force	es?		If Yes, sp	ecify Cuba	an, Mexica	n, Puerto F	Rican, etc.)			k, White,		
36	rs af	by F	3 ⊠ Widowed 4 □ Divorced	If Yes, Give Year or Date			1 🗆 Yes	2 X No	Specify:	:			Specify:	D 1	ack	
Ş	tura tura	ed	15. Decedent's E		-	16a. Dece	dent's Us	ual Occup	ation			16b. K	ind of Bu			
5	n 72	Completed	(Specify only highest gra	de completed)		(Give	kind of w	ork done i use retired	during mos	st of workir	ng		artme			
12	within and the state of the sta	Ĕ	Elementary/Secondary (0-12)	College (1-4 4	or 5+)				•			_	atio		_	
2	Hygin II		17. Father's Name (First, Middle, Last,			Finar	iciai	Ana		er's Name	(First, Middle					
ano	d o d	Be	William Handy								Wainri			-,		
Ž	d Me	2	19a. Informant's Name/Relationship (E Driet		10h Maille		- /C++			Route Numb		Town	Ctota 7:-	Codel	
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: if Item 27 is marked other then "natural", or itema 23a or 28a-f show amy injury or other traumatic event, the Madical Examiner must be notified at ance.		(1)				•				Mitch				,	1
d)	tealth m 2		Lisa Price/ Daugh	iter	20h 5	Place of Dispo			TOOK		ate			-	wn, State	
Baltimore,	i of i		1 X Burial 2 □ Cremation 3 □	Removal from St		cometery, crer Laken	matory or	other plac	ce)	D.	ate	20C. L	ocation -	City or 10	IWII, State	
Ξ.	Pag men ant: ury		4 □Donation 5 □ Other (Specif	r)	Men	norial	Gard			07/21	1/2006	Davi	idsor	vill	e, MD	
a	Depart Import any inj		21. Signature of Funeral Service Licer	ise		22	2. Name a	and Addre	ss of Facili	ity Rob	ert E.	Eva	ins F	uner	al Hor	ne
<u>m</u>	90F # 9		FIORU	/		1	16000	Ann	apoli	s Roa	ad Bowi	ie, N	1D 20	715		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau	sed the deat	th. Do not ent	ter the mo	de of dyin	ng, such as	cardiac o	r respiratory a	rrest,			Approximat Interval Bet	ween
	Physician		tmmediate Cause (Final disease or condition	, Vagina		ror									Onset and	Death
	/Medical		resulting in death)	· · · · · · · · · · · · · · · · · · ·	as a conseq											
	Examiner			Dement	ia											
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a conseq	juence of):										-
	beau ansit	퉅	Cause (Disease or injury that initiated events													
,	n and	Examine	resulting in death) Last	Due to (or	as a conseq	uence of):										
8760,	icate be executed physician and s the burial-transit	dlcal		d												
687	ficate phy s the	g		u												
×	ding rese e	×	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna	ancy							23d. Date	of delive	erv	
Box	atter for u	clar	in the past 12 months?		h 2 ∐ Feta nt at time of d		□Ectopic □ Other (s	pregnancy specify)	/				Mor			Year
Ö	the d	Physician/M	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9□ Unknow				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
P.0	requires that the death certificenes signed by the attending the ould be detached for use es		Part II. Other significant conditions of	ontributing to dea	th but not res	sulting in the u	nderlying	cause giv	en in Part 1	t,	23e. Did	tobacco	use contr	ibute to th	ne cause of c	death?
Records,	se us es	1 by									10	Yes 2	□XNo	3 ☐ Prob	abty 4 □t	Jnknown
Ö	w requir been si should	Completed									-		1			
ec	es co co	d									24a. Was auto	psy	P	rior to co	psy findings mptetion of c	available ause of
=	Page Page	ပ္ပံ									1 ☐ Yes	ormed? 2 No		eath? □ Yes	2□ No	
Vital	ysician: Th iis certificate director, pag	Be	25. Was case referred to medical examiner?							e of Death	(Check only	one)				
of V	Z ≥ 0	2	1 ☐ Yes 2 🔯 No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatier	nt 3 🗆 🖸	OA Oth	er: XXN	ursing Hon	ne 5 🗆 Resi	idence	6 □Othe	r (Specif	v)	
0	ng Pi ter ti		27. Manner of Death 1 XNatural 5 □ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time o	f	28c. Injur Wor	y at rk?	2	8d. Describe	how intu	ry occurre	∍d		
Ö	Attending r death. Sctor: After oy the fune	atlc	2 ☐ Accident investigatio				М		Yes 2□	No						
Division	ar de	100	3 Suicide 6 Could not b	28e. Place of	Injury - At h	ome, farm, sti	reet, facto	ry, office		2	8f. Location (City or To			er or Rura	I Route Nurr	ber,
Ö	s afte	Certification:		January		**					.,	, _1010	,			
	Hospital 24 hours a Funeral tely filled	al	29a. Certifier 1 Certifying Pt	ysician: To the b	est of my kno	owledge, deat	h occurre	d at the tir	me, date ar	nd place, a	nd due to the	cause(s) and mai	nner as s	ated.	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Examone)	niner: On the bas and manne	r stated.	ation and/or in	vestigatio	n, in my o	pinion, dea	a(n occurre	at the time,	date and	o piace, a	na due to	the cause(s	5)
	withir To th	Ž	29b. Signature and title of certifier				2	9c. Licens	e number			29d. Da	te signed	(Month,	Day, Year)	
			16 -				T	5818	2		C)7/1	7/200)6		
			30. Name and address of person who	completed cause	of death (tter	m 23a) (Tvpe.		.5010				,	, 200			
			Cecil Donald Geo:			Hanove		kwav	#A G	reenl	oelt. N	1D 20	0770			
	Sta	ate	31. Date filed (Month, Day, Year)		gistrar's Signa						, •					
	Regist		IIII 1 Q 2		_	4	0									

Pleas	e Type or Prin	it in Black Inc	delible Ink.	Ensure Al	l Copies A	re Legibl	le.
For Stata	State of Ma	aryland / Depa	artment of He				15 2444
Registrar 1. Decedent's Name (First, Middle,	l ast)	001	tineate of E	Catir	2. Date of Death	g. No.	3. Time of Death
John A. Nelsor	·				July	17, 2č	006 9:23 am
4a. Facility Name (If not institution,			4b. City, Town, or	Location of Death		4c. County of	
Howard County H			Colu			Hov	vard
5. Social Security Number 212-46-2115	5. Sex 7. Age 1. M 2 ☐ F	e (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 10/28/1	944). Birthplace (State or Foreigr Country) Mary Land
Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
							1 ☐ Yes 2 🗗 No
Md. Howa	ara	Columb	10f. Zip Code		10	g. Citizen of Wh	at Country?
5001 Columbia	a Road Apt 2	202	2104	4	10	USZ	-
11. Marital Status 1 Never Married 25 Marrie 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? d 1 2 Yes 2 N If Yes, Give Year or Dates:	lo 1965 –	Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2X No	spanic Origin? (Spe i, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black,	American Indian, White, etc. Black
15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)	16a. Deced	dent's Usual Occupa kind of work done do DO NOT use retired)	tion uring most of work	ing 1		County Board
12yrs	Oundge () to a	N	Might Buil	ding Sup	ervisor	of I	Education
17. Father's Name (First, Middle, La	ast)			18. Mother's Name		,	
Leroy Nelson				T-T-T	lian Bla	ckstone	
19a. Informant's Name/Relationshi	р (Туре, Print)	19b. Mailin	ng Address (Street a	nd Number or Rura	al Route Number,	City or Town, St	ate, Zip Code)
Martha A. Nels 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spa	B □Removal from State acify)	20b. Place of Dispo cemetery, cren Crownsvil	natory or other place Le Vetera . Name and Address	ns 7/25,	/2006 (ry H.Wit:	Oc. Location - Ci Crownsvi zke's Fa	ty or Town, State
23a. Part1. Enter the disease, or c	omplications that caused	the death. Do not ent	er the mode of dying	, such as cardiac o	or respiratory arre	st,	Approximate
shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	_aVentri	cular Fibr a consequence of):	illation				Interval Between Onset and Death 5 minutes
Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	а сопзациенса UI).			destroits at the	·	
resulting in death) Last	Due to (or as	a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
Part II. Other significant condition	s contributing to death be	ut not resulting in the u	nderlying cause give	n in Part I.			ute to the cause of death?
					24a. Was an autopsy perform 1 X Yes 2	ed? prid	ore autopsy findings available or to completion of cause of ath?
25. Was case referred to medical examiner?				26. Place of Death	(Check only one)	
1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatie	nt 2 XER/Outpatien	it 3□ DOA Othe	r: 4 🗆 Nursing Ho	me 5 Resider	nce 6 Other	(Specify)

/Medical Examiner attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the a d be detached f

Physician

Physician

/Medical

Examiner

Funeral

Director

"natural", or Itame 23a or 28e-f show adical Example must be mutified at

Director

Completed by Funeral

To Be

27. Manner of Death

1 X Natural

2 Accident

3 ☐ Suicide

4 Homicide

29a. Certifier

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be lifed within 72 hr. Department of Health and Mental Hygiene. Importent: if item 27 Is marked other than "natur any injury or other traumatic event, It a Medical once.

Baltimore, Maryland 21215-0036

Examine Completed by Physician/Medical should has page certificate To Be After thi Medical Certification:

within 24 hours after death

To the Funeral Director: /

Division of Vital Records, P.O. Box 68760,

death.

31. Date filed (Month, Day, Year) State Registrar

5 Pending investigation

6 Could not be determined

29b. Signature and title of certifier

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

🔁 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29c. License number D29888 July 17,2006

28a. Date of Injury (Month, Day Yeer)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Leichtling 5450 Knoll N. Drive Columbia, Md. 21045



			1 - For State Ragistrar	Si	tate of N	Marylan	-	artmen rtificate			and M	lental Hy	gien Reg. N	Z 1111b	2444	
	Physici	an	1. Decedent's Name (First, Middle	Last)								2. Date of De Month	Da	ay Year	3. Time of Death	
	/Media	al	Mary E. Ottes 4a. Facility Name (If not institution			a-1		4h City	Town or	Lagation	of Donath	July 1		006 c. County of Deat	6:10 p	M
	Examir		4513 Valley Forg	-		91)		Rocky		Location of	n Death			ontgomer		
	Funeral		5. Social Security Number	6. Sex	7.	Age (In yrs. I	last birthday)	If Under	1 Year	If Under		8. Date of Bi			hplace (State or Fore untry)	ign
	Director		501-16-9287	1 □ M	2 XF	84	Yrs.	Months	Days	Hours	Min.	10-23-	l 921	Nort	h Dakota	
	pu ,		Usual Residence of Decedent			100 Cit	v. Town or Lo								10d Inside Oits Limi	to
	shov ed at	5	10a. State 10b. County					cation							10d. Inside City Limi 1 ☐ Yes 2 🛣	
	the M	Directo	Maryland Montgo	mery		Kock	ville	10f. Zip	Code				10a C	itizen of What Co		
	with 3a or							101. 2.0	2085	53				ted Stat		
	death ms 23	Funerai	4513 Valley Fore	e Dri	Ve Vas Decede	nt Ever in U.	S. 13.	Was Deced			gin? (Spi	ecify Yes or Ne Rican, etc.)		14. Race - Ame	rican Indian,	
9	or Ite	Ē	1 ☐ Never Married 2 → Marri	ed 1	Armed Force ☐Yes 2[f Yes, Give	nt Ever in U. s? No		iryes, spec 1 □ Yes 2		n, Mexican Specify:		Hican, etc.)		Black, White Specify: Wh		
933	urel',	d by	3 Widowed 4 Divorced	`	ear or Date	s:										
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23a or 28a-1 show Its Mailcel Examitter i ust be notified at	Completed	15. Decedent (Specify only highes				16a. Dece (Give	dent's Usua kind of wor DO NOT us	il Occupa rk done d	ation <i>luring most</i> 1	t of work	ing	16b. F	Kind of Business/	Industry	
12	withii iene. then	m _o	Elementary/Secondary (0-12)		College (1-4d		Housew		,0 ,0,,,00,	,			Ow	n Home		
b	e filed Il Hyg other	a	17. Father's Name (First, Middle,	.ast)						18. Mothe	er's Name	First, Middle				
/lar	should be filed with nd Mental Hygiene. marked other ther imatic event, the	To B	John Studam Wilk	inson	l .				1	lary l	Meli	ssa Ric	har	dson		
Maryland	C1 62 50		19a. Informant's Name/Relations! Ronald Ottes- S											or Town, State, Z		
	1 and Health em 27		20a. Method of Disposition	Pouse	•	20b. P	lace of Dispo			nge i		Date		ocation - City or		-
Baltimore,	Pages nent of I		1 ☐ Burial 2 X Cremation		val from Sta	ite C	emetery, crei	natory or o	ther place					xandria,		
Ħ	artme orten injurg		 4 □ Donation 5 □ Other (S) 21. Signature of Futeral Service 		10	1	22	2. Name an	d Addres	s of Facilit	ySim	-2000 ple Tri	but	. 1040	Rockville	_
B	permit. Departr Importe any inji		Den Small	-dr	Three	lu/						20852		, 1040	ROCKVIIIC	
			23a. Part1. Enter the Isease, or shock, or heart failure. List	complicationly one ca	ons that caus	he death	. Do not ent	er the mod	e of dying	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between	
8	Physician		Immediate Cause (Final disease or condition	a S	troke										Onset and Death	
	/Medical Examiner		resulting in death)			as a consequ	uence of):									
		<u>ة</u>	Sequentially list conditions, if any, leading to immediate	b	Due to (or	as a consequ	uence of):									
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, listeds or in july that initiated events	1												
o,	an an	Exa	resulting in death) Last	J	Due to (or	as a consequ	uence of):					-				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ledicai I		d												
9 xo	death certifica attending ph for use as th	/Med	IF FEMALE:	23c. l	f ves. outcor	ne of pregna	ncv							23d Date of deli		
Bo	atten I for u	Physician/M	23b. Was decedent pregnant in the past 12 months?		1 ☐ Live birth	2 Fetal	death 3	Ectopic pro						23d. Date of deli Month	Day Year	
0	that the de led by the a detached t	hysi	1 □ Yes 2 X No 9 □ Unknown		9□ Unknowr				,,							
S, D	res that igned b	by P	Part II. Other significant condition	ns contribu	uting to death	h but not resu	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did	obacco	use contribute to	the cause of death?	
ğ	w require been sig should b							_				1 🗆	Yes 2	! Mo 3 □ Pro	obably 4 Unknov	vn
Records,	law ri as be	Completed										24a. Was	psy	prior to o	topsy findings availab completion of cause o	ole f
= "		Con										perfo 1 ☐ Yes	ormed? 2 🏹 No	death? 1 ☐ Yes	2□ No	
Vital	Physicien: The lar this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hosp	ital-				Othe			(Check only				
of	Phys r this ral di	T.	1 Yes 2 XNo 27. Manner of Death		1 ☐ Inpa		ER/Outpatier 28b. Time of		_	4 140		me 5 x Resi 28d. Describe		6 ☐Other (Spec	cify)	_
on	Attending Ph r death. sctor: After th by the funeral	tion	1 XNatural 5 ☐ Pendin 2 ☐ Accident investig	9	(Month,	Day Year)	Injury	м	8c. Injury Work 1 ☐ 1	:?ົ` /es 2 ∐ !				.,		
Division	Attendi	ifica	3 Suicide 6 Could r	ot be			me, farm, str	eet, factory	, office			28f. Location (City or To			ral Route Number,	
ā	tal or A s after el Direc ed in by	Certification;	4 Homede		building,	etc. (Specify	// 					City or 10	wn, stat	θ/		
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical	xaminar:	On the basis	s of examinat	wledge, death tion and/or in	occurred a	at the tim	e, date an	d place, th occurr	and due to the ed at the time,	cause(s	s) and manner as id place, and due	stated. to the cause(s)	
	To the H within 24 To the Fi	Med	one) 29b. Signature and title of certifier		and manner	stated.		29c	. License	number			29d. Da	ate signed (Month	i, Day, Year)	
	F3F8		> Patricia	10m	ske	Ma	9, 70	0 -	5191					17, 200	,,	
,	3		30. Name and address of person	vho comple	eted cause of	of death (Item	23a) (Type,	Print)						-		
_			Patricia Tomsko	Nay,						G-10	0, R	ockvil:	Le,	MD 20852		
	Sta Registi		31. Date filed (Month, Day, Year)													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** ANTON PICKA Julv 21 2006 10:40 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Genesis HealthCare The Pines Easton
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** JULY 19,1912 Days Hours Months Min. MARYLAND 94 216-01-5001 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or items 23a or 28e-f show adical Examiner must be nutified at Yes 2 No Director MD TALBOT EASTON 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 21601 610 DUTCHMANS LANE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? La Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "ne any injury or other traumatic event. If a Media once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AUTOMOBILE ASSEMBLY MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ANTON PICKA ELLA NEUMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES G. PICKA/SON PO BOX 189 WITTMAN, MD 21676 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 7/22/2006 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee Name and Address of Facili FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Joseph m Ustrowsk 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical ф as IF FEMALE: use If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? <u>م</u> CIAME 2 No 3 Probably 4 DUnknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Ursing Home 5 Residence 6 Other (Specify) Hospital: 9 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending 1 🗌 Yes 2 □ No death. investigation 2 Accident Director: Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral I f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Mopth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ++ NA ROBERT B. SANCHEZ M.D. 508 IDLEWILD AVE. EASTON, MD 21601 32 Agistrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Martha 800P Remsburg **Physician** 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Medical Center Baltimore Baltimore 5 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days | Hours | Min. A P R . 28 Year) 9 5 3 Birthplace (State or Foreign Country)
 MD 5. Social Security Number **Funeral** 1 M 2 F Months 212-64-4521 53 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 28e-f ehow or then "natural, or items 23a or 28e-f ehover the Medical Examiner must be notified at ST. MARY'S MD 1 ☐ Yes 2 No CALIFORNIA Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45936 HALSEY CT. 20619 USA by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 ☐ Married 1□Yes 2☑No Baltimore, Maryland 21215-0036 Specify Specify: WHITE 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) CACI, INC. Elementary/Secondary (0-12) College (1-4or 5+) WIRE MAN ELECTRONICS 12 and Mental Hygi permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth ery linjury or other treumatic event SDR.B. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) OWEN JOSEPH REMSBURG MYRTLE BEALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5915 LAUREL CT., ADAMSTOWN, MD MARY PHILLIPS / SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place)
PLEASANT VIEW CEM. 20c. Location - City or Town, State 20a. Method of Disposition JULY 24 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BURKITTSVILLE. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HILTON FUNERAL HOME
P.O. BOX 86, BARNESVILLE, MD Approximate Interval Between Ofset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hemorrhage Physician erebial /Medical Examiner Mheurysm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) as the burialettending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Chack only one) and manner stated. To the 1 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of gertifier 17511 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Baltimire Maryland 22 South Greene Street Maulucci Christopher

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar		Marylar		artmen rtificat			and M		Reg. No.	2006	24	147
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-	shoul mark mati	P L	19a. Informant's Name/Relationship	p (Type, Print)		19b. Mailir	ng Address	(Street a				tale er, City or	Y Town, State, Zi	o Code)	
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show says injury or other treumatic event. The Mydical Expulsion must be notified at ance.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ➡ Widowed 4 □ Divorced	Armed F	2XXNo		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.))-	Bla	ce - Americ ck. White, fy: Whit	etc.	
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			30 Name and address of person w	ho pleted car	se of death (Ite	m 23a) (Type	, Print)	~			the st	0		^	0	N4 .a
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I	Funeral Director		5. Social Security Nur 219-32-7	133	5. Sex 1 □ M 2 🖾 F	7. Age (In yrs 70	s. last birthday) Yrs.	If Und Month	er 1 Year s Days	If Under 24 Hours		Date of Bird (Month, Da eb. 2	th (Year)	36	. Birthpl Coun	ace (State or Foreign try) MD
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Iteme 23e or 28e-f ehow any figury or other traumatic event, The Medical Examinat must be notified at anotes.	al Director	10e. Street and Numb				JCEAN 1		Zip Code 21811				10g. <i>C</i> iti	izen of Wh	at Coun	try?
920	urs after des	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4		Armed F	2 X No ive	ŀ		edent of His becify Cubar 20XNo	panic Origin , Mexican, P Specify:	? (Specif Puerto Ric	fy Yes or No can, etc.)		14. Race - Black, Specify:	White, e	etc.
Maryland 21215-0036	vithin 72 hou ne. han "naturi e Wedleal E	Completed	(Specify Elementary/Second		grade completed) (1-4or 5+)	(Give	kind of 1 DO NOT	sual Occupa vork done di use retired) omema k	uring most of	f working			ind of Busin	ness/Ind	ustry
land 2	ld be filed v ental Hygle ked other t ic event, in	To Be Co	12 17. Father's Name (F Theodore					п		18. Mother's		First, Middle,	Maiden	Sumame)		
, Mary	and 2 shou saith and M n 27 is mar ier traumat		19a. Informant's Nam	ne/Relationship	o (Type, Print)		18 0	ffsk	ore L	ane, C	r Rural F	Pine	er, City o	r Town, Sta		Code)
Baltimore,	t. Pages 1 tment of He rtant: if Iten ijury or oth		20a. Method of Dispo 1 ☐ Burial 2 🕅 4 ☐ Donation 5	Cremation 3	ocify)		Place of Dispo cemetery, cren yview C	rema	tory	7		/2006	Ва	ltimo	re,	MD
Ba	Depar Impod any Ir		21. Signature of Fune	Trill	Buta	-	1	08 V		m St.,	, Ber	Burb clin,	MD 2			
7	Physician /Medical Examiner	Iner	23a. Part1. Enter the shock, or heart Immediate Cause (Fi disease or condition resulting in death) Sequentially list condition, to add the cause. Enter Underly Cause (Disease or in Cause, Classes or in Cause, Classes or in Cause, Cause, Classes or in Cause, Ca	naí	a Due to		quence of):			such as can		espiratory ar	Test,			Approximate Interval Between Onset and Death
68760,	ificate be executed g physiclen and as the burial-transit	edical Examiner	Cause (Disease or in that initiated events resulting in death) La		c. Due to	(or as a conse	quence of):									
		Physiclan/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 2 3 9 □ Unknown	onths?	1□Live	Itcome of pregr birth 2 □ Fet nant at time of nown	tal death 3	Ectopic Other (pregnancy specify)				4	23d. Date o Month		y Day Year
rds, P	w requires that been signed b should be deta	۾	Part II. Other signific	ant conditions	s contributing to	death but not re	sulting in the ur	derlying	cause give	in Part I.	_		obacco u	-		e cause of death?
al Reco	: The law racate has be page 2 shu	Completed										24a. Was autop perfor	sy med?	prio dea	r to com	sy findings available ipletion of cause of
Division of Vital Records,	To the Hospitel or Attending Physicien: The law requires that the death cert within 24 hours after death sometimes as after death state of the strength Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use in	ıtlon; To Be	25. Was case referred examiner? 1 ☐ Yes 2 ☒ No. 27. Manner of Death 1 ☒ Natural 2 ☐ Accident		28a. Date (Mor		28b. Time of Injury	3 □ t	28c. Injury Work	4 ☐ Nursir	ng Home	5X Resid	lence 6		(Specify)	
Divisi	tel or Atter rs after dea al Director ed in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	t be 28e. Plac	e of Injury - At t ling, etc. (Spec	nome, farm, stre	et, facto			28f	Location (S City or Tow	Street and In, State)	d Number o	or Rural	Route Number,
	To the Hospitel or & within 24 hours after To the Funeral Dire completely filled in b.	Medical	one)	☐ Medical Ex		nasis of examin ner stated.	ation and/or inv	estigatio	n, in my opi	nion, death o	occurred	at the time, o	date and	place, and	due to t	the cause(s)
	T M S	_	200. Signardre and III		lan	m.5	7 .		9c. License	0690	>		500 Date	e signed (A	onin, D	ay, rear)
	3 Sta	te	Jones E. 31. Date filed (Month,	Day, Year)	7 / M	Degistrar's Sign	ature	rint)	(1	57	, -	Salis	50 -	7,	n E	2 1 801
	Registr	ar	.11	1 2 1	2006	Section 1	14 160	ade								

State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#16aperFH7/20/06, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** Wilfred E. 1503 M 1.1 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year II Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 18M 2 F Director 577-44-4215 73 April27,1933 Washington D.C. Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits if Item 27 is marked other than "natural", or Itams 23s or 28s-f show goother traumatic svent, the Musical Examiner must be motified at 11 Yes 2 No Director Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13101 Parkland Dr. 20853 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:W • W • II Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2√ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Computer 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Computer 4 I.R.S. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 end 2 should be filment of Health and Mental H tant: if Item 27 is marked ot Wilfred E. Shisler Sr. Lillian Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha C. Shisler (Wife) 13101 Parkland Dr. Rockville, Md. 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tx⊠Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: if any Injuryer once. Ft.Lincoln Cemetery July 20,2006 Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Chambers funeral Home & Crematorium, P.A. hams 5801 Cleveland Ave. Riverdale, Md. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** durathic /Medical Due to (or as a consequence of) Examiner S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death 1 ☐Yes 2 ☐No be detached 9□ Unknown 9 Unknown δ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 🖜 3 Probably 4 Unknown been Mellitus 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death? has autopsy performed certificete EIN 1 ☐ Yes 2 ☐ No) ee 1) 1 ☐ Yes 2200 or Attending Physician: 25. Was case eferred to medical examiner? Certification: To Be 26. Place of Death Check only one) Hospital: 1 < npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No this To the Funeral Director: After the completely filled in by the funeral 28b. Time ol Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospitel or Attendii within 24 hours after death. To the Funersi Director: A investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 08/11 AKO11 D 53317 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road 213 Contherbuy 16222 Frederick 3. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month **Physician** 2006 July 11, 8:55P Lalmama Sailo /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Yrs. India Director 212 80 6003 Sept 10 1934 71 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel; or iteme 23s or 28s-1 show amountment: it item 27 is marked other then "naturel" or iteme 23s or 28s-1 show any injury or other treumatic event; it is Medical Esaminar must be notified at once. 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ₩ No **Funeral Director** Maryland Prince George's **Greenbelt** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6806 Springshire Way 20770 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritat Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Asian ģ 3ÆWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Etementary/Secondary (0-12) 5+ Professor **Higher Education** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sailo Sailo Ronguava Kaichhingi 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Canterbury/ Daughter 20783 7112 West Park Drive Hyattsville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State George Washington Cem 7/23/2006 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funeral Service Vicensee 22. Name and Address of Facility Hines Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD 20904 234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Mesenteric Infarction Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed the attending physicien and the for use as the burial-transif that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical the : IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ፩ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Cardiomyopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown cate has been signate, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension this certificate has autopsy performed? 1 Yes 2 No 1 Yes 2√ No Division of Vital Peri Colostomy Hemorrhage To the Hospitel or Attending Physician: within 24 hours after death.
To the Funerel Director: After this certification place of the funeral director, is completely filled in by the funeral director, it 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturat 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Intury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier TC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D20772 July 12, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira R. Tannebaum, M.D. 1145 19th Street, N.W. #113 Washington, D.C. 20036 31. Date filed (Month, Day, Year) 32. egistrar's Signature State DRACE JUL 2 0 SUUR Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician Carlton 2006 Eugene Ju1y 1911:43 P. /Medical Stevens 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kline Hospice House Mt. Airy Frederick If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Jan. 22,1934 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** DOM 2 F Hours **Director** Maryland 220-28-4180 Usual Residence of Decedent with the Maryland item 27 is marked other than "natural", or items 23s or 28e-f show other traumatic event, the Madical Examinational be published at 10c. City, Town or Location 10d. Inside City Limits Maryland

10e. Street and Brunswick 1 XYes 2 No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 Peach Orchard Lane 21716 Funerai death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural; or iten any injury or other traumatic event, the Mudical Erann once. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Accountant U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stevens Viola Ecker ျှ Raymond Ε. Lena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1055 Peach Orchard Lane, Brunswick, MD 21716 Raymond Stevens/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 24,06 Frederick, MD Frederick Crematory 21. Signature of Funeral Service 22. Name and Address of Facility Stauffer Funeral Home, PA 1100 North Maple Avenue, Brunswick, MD 21716 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic obstructive sulmorary years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 1 No 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death Check only one Hospital: 1 | Inpatient | 2 | EP/Outpatient Other $_{4}$ Nursing Home $_{5}$ Residence $_{6}$ Nother (Specify) Hospice2 3 DOA After thi funeral 27. Manner 1 Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation To the numbers after death.

Within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32073 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ND Stem are Brunswick Md 610 Ninth Kathleen 31. Date filed (Month, Day, Year) JUL 2 1 32. R gistrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year Helen Catherine Bolden Shambley-Stalling 2:02 P M July 2006 14, /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bowie Health Care Center Bowie Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Days Months Hours Min. 1 □ M 2 1 1 F 256-20-4408 82 Director 11/01/1923 Florida Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City, Town or Location item 27 is marked other then "naturel", or iteme 23a or 28e-f show other traumatic event, the Modical Examinar must be notified at 10d. Inside City Limits XXYes 2 □ No Funeral Director Maryland Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20716 3712 Excalibur Court Unit 203 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2X No Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by If Yes, Give Year or Dates: 3

Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life, DO NOT usa retired)
Contract Compliance 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "na any Injury or other traumatic event, the Madis 2008. Elementary/Secondary (0-12) College (1-4or 5+) United States Department Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Edward Bolden Evelyn Arthelia Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol S. Cochran/ Daughter 11410 Waesche Drive Mitchellville, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cometery, crematory or other pla National Harmony Memorial Park 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/20/2006 Largo, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner IRM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and the for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal de. 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death detached for in the past 12 menths? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of deeth Year 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 🗖 No Completed 1 □ Yes 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No 1 Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner¹ Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 PR/Outpatient this 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t Certification; 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number ddress of person who completed cause of death (Item 23a) (Type, Print) 4000 KON 31. Date filed (Month, Day, Year) egistrar's Signature State 19 2006 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1 Decedent's Name (First, Middle, Last) **Physician** 07-13-2006 6:25 PM Ethe1 Alma Simpson /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street and number) Examiner Caroline Denton Hospice 6. Sex Caroline If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) 5. Social Security Number Hours **Funeral** Days Months 1 □ M 220 F 01-27-1930 Director 216-30-6154 76 Maryland Usuel Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10e. State 10b. County r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 □ No Directo Maryland Caroline Denton 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 205 Caroline apt. 21629 USA Funerai within 72 hours aftar death 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: ģ 3 Widowed 4 ☐ Divorced **Black** Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within al Hygiana. own home and College (1-4or 5+) Elementery/Secondary (0-12) Some one else's home 4 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Pagas 1 and 2 should be fill mant of Haalth and Mantal Hant: If Itam 27 is marked oth Be Isabelle Randa11 Gray James 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rep 1108 Canvasback Lane, Denton, Maryland 21629

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 2cc. Locaron - City or Town, State Ruth Heitmuller /Personal 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 4 ☐ Donation 5 ☐ Other (Specify) SpringGrove Cemetery 07-19-06 Denton, Maryland 22. Name and Address of Facility
Bennie Smith Funeral Home 21. Signature of Funeral Service Licensee 426 Dover Street, Easton, Maryland 21601 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examine or Attending Physician: The law requires that the death cartificate be executed physician and s tha bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. been signed by tha a should be datached 1 X Yes 2□ No 3 ☐ Probably 4 ☐ Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed s cartificata has b 1 Yes 2 YUNO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) diractor, Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Medicai Certification: To 1 ☐ Yes 2 No 3□ DOA 28a. Date of Injury (Month, Day Year) Aftar this 28b. Time of Injury 28c. 28d. Describe how injury occurred 27. Manner of Deeth Injury at 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours aftar daath.

To the Funerel Director: Af
complataly fillad in by tha fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide the Hospital 1% Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 47232 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Registrar **DHMH 16 Rev 6/95**

State

, 401 Commerce

De Shields,

Mary S.

31. Dete filed (Month, Day, Year) JUL 1 9 2006

M.D.

Registrar's Signature

St., Suite 101, Easton, Maryland 21601

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 21^{Day} July 2008 **Physician** 11:58pm M Anna M. Swarner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Ravenwood Lutheran Village Hagerstown

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 11–21–1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Yrs. Director 214-07-2435 88 Frostburg, MD Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in than "natural", or Itema 23a or 28a-f show the Medical Examiner must be notified at 1 Tes 2 No Director Maryland Washington Hagerstown, Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 United States 16952 Shady Brook Terrace Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Self Employed 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is markad oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frances Bollinger O'Grince Louis O'Grince 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13811 Weber Way, Hagerstown, MD 21742 Sue Britton/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Memorial Garden | July 24,2006 Curberland, Maryland 22. Name and Address of Facility Douglas A. Fiery Fureral Home 21. Signature of Funeral Service License 1331 Eastern Blvd., North, Hagerstown, MD 21742 anie 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Guiter seculday disease or condition resulting in death) Consentin /Medical Due to (or as a consequence of): Examiner Schendie Curcho Vasan dens you Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Junknown Chromz 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an iannicus autopsy performed? 1 ☐ Yes 2 1 NO Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Arising Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. М 2 Accident after death Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Momicide 0 To the Hospital within 24 hours a To the Funeral C 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier - (2C) M) 12 (8015 JULY 22, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VASANT DATTA ano 340 MILL 5 7 HALERSTOWN M121740 32. Registrar's Signature 31. Date filed (Month, Day, Year) State and I 2 4 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 17, 2006 9:30 P M Donna Jean Taylor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 7003 Opal Ct. Middletown 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign 1947 Country) MD If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 X F 219-46-0025 59 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. fnside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene and it if item 27 is marked other than "natural; or itema 23a or 28a-f ahow and it if item 27 is marked other than "natural; or other thanmal te and it is Medical Exeminating the natified all Frederick Middletown 1 Yes 2X No MD Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21769 USA 7003 Opal Ct. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritaf Status 1 ☐ Yes 2€XNo tf Yes, Give Year or Dates: 1 ☐ Never Married 2X Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tax service office manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth Alice Speir Donald Lee Flanagan ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Taylor (Husband) 7003 Opal Ct., Middletown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burja 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Lutheran Cemetery 7/22/06 Middletown, MD 4 □ Denation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 23a Part1. Enter the disease, or complications that caused the shock, or yeart failure. List only one cause on each line. caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) adenocarcinoma of **Physician** years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 PNo 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D20488 7-20-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIDDLETOWN, MD. 21769 Dessler mo POBUX 20 ames 31. Date filed (Month, Day, Year) 32. Signature State Registrar

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	permit. Pages Department of I Important: If its any injury or o		21. Signatura f Funeral Service	e Licensee					cility Star	uffer F	unera	al Home	, P.A.,
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_	<u>> 20 </u>	2	1 ☐ Yes 2. ☐ No	Hospital: 1	mpatient 2	ER/Outpatien		Other: 4	Nursing Hor	me 5 Resid	lence 6	□Other (Spec	cify)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 19a per inf. 8-3-06vt. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 4:52 p July 22, 2006 Ralph **Emmett** Wilburn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery Sex M 2□F If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Min Yrs. 227-66-7993 58 Nov. 26, 1947 Director Virginia Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location in than "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 XYes 2 No Director Va. Montgomery Blacksburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3110 Meadowbrook Drive #45 United States
14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or ite any injury or other fraumatic event, the Medical Examinat 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Maryland 21215-0036 Specify: White Specify: ģ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Complet Alliant Techsystems Elementary/Secondary (0-12) College (1-4or 5+) Radford Army Ammunition 12 Materials Dept 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Clarence Woodson Wilburn Dorothy May King 19a. Informant's Name/Relationship (Type, Print) wife 19b.
Maria de Sena Das Candeias Wilburn
Maria de Senadas Candeias Wilburn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3110 Meadowbrook Drive #45 Blacksburg Va.24060
Disposition (Name of Date 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)

21. Signature of Funeral Service Liberts Westview Cemetery July 26, 2006 Blacksburg, Va. 22. Name and Address of Facility Dougan McCoy Funeral Home, Inc.
150 Country Club Drive SW. Blacksburg, Va. 24060

Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Embolus Physician ulmonas /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wiknown been si should I 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No 1 ☐ Yes within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 PR/Outpatient 3 DOA 28c. Injury at Work? 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 1 Matural Injury 5 Pending investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatury and title of certifier 06 22 30. Name and address of erson who completed cause of death (Item 23a) (I Av. : Takoma Parle MD 20912 7600 J.D. Carrol Zu Humayun 31. Date filed (Month, Day, Year) 32 Degistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 0 3 2006

20062

6-05081			Please Type or	Print in	Black I	ndelible li	nk			
obert Henry Woo	1 F	- For State	f Maryland / Depa		f Health	and Ment	al Hygiene	Reg. No.	200	
Physician Medical Examina	7	1. Decedent's Name (First, Middle,Last) ROBERT HENRY WOO	LDRIDGE, JR.				2. Date of D Month July 15,	Day	Year	3 Time of Death 1331 hrs
		4a Facility Name (if not institution, give s Prince Georges Hospital Ce	street and number)		4b. City, To	wn, or Location o	f Death		. County of Death rince George	
Funeral Director		5. Social Security Number 6. Sex 1 X N	7. Age (In yrs. I	ast birthday) Yr:	If Under Months	1 Year If Under Days Hours	Min	•	DD/YYYY) 9 Bird Foreig 81,1951 ^{Col}	
vith the Maryland 7.23a or 28a-f show any notified at once.	ا ه	Usual Residence of Decedent	RY SILV	, Town or Loca VER SPR		Code 20903		-	zen of What Cour	10d Inside City Limits 1 Yes 2 No
or items	Funeral	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No Yes, Give Year		Yes, specify	t of Hispanic Orig	in? (Specify Yes or Puerto Rican, etc.)	No-	14 Race - Ameri White, etc.	
11215-0036 Id be filed within 72 hours after femial Hygene. roarked other than "natural";	Completed by	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	college (1-4 or 5+)		nost of worki	ng life DO NOT			SPORTS	ndustry
	8	17. Father's Name (First, Middle, Last) ROBERT HENRY WOO 19a Informant's Name/Relationship (Type		19b. Mailir	ng Address	BEVE	s Name (First, Middl RLY PARMI. ber or Rural Route N	A OBE	R	Zip Code)
ore, MD s 1 and 2 sho of Health and If item 27 is		MRS VALERIE WOOLDR 20a Method of Disposition 1 XBurial 2 Cremation 3	IDGE - WIFE 20b.	1052 Place of Dispo crematory or o RKLAWN M	sition (Name	of cemetery,	PARKWAY, Date JULY 20, 20	20c. l	R SPRING Location - City or DCKVILLE,	
Balt Permit Depart Impor injury		Donation 5 Other Specify Signature of Europeral Service License And American Service License And American Service License And American Service License And American Service License		11	800 NE	W HAMPSI	HIRE AVE.	, SIL	VER SPRI	HOME, INC. NG, MD 20904 Approximate Interval
Physician /Medical Examiner		failure List only one cause on each $ \mbox{Immediate Cause (Final disease} \qquad \mbox{a.} \begin{picture}(100,0) \put(0,0){\line(1,0){100}} \put(0,0){\$			the mode of	dyllig, sacri as ca	ardiac or respiratory	arrest, sire	or near	Between Onset and Death
pa ist	Examiner	cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	ue to (or as a consequence of							
760, icate be executed physician and the burial - trans	dical	dUNPENDED	AMENDED							
OX 68 eath certif		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 4 Pregnant at time of de 9 Unknown	2 F	etal death Other (Specil		pregnancy	230	d. Date of delivery Month E) Day Year
ires that the de signed by the detached if	হ	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying o	cause given in Pa			_	the cause of death?
Division of Vital Records, ra after death. The law requirers after death. The law requirers after this certificate has been a birector: After this certificate has been seled in by the funeral director, page 2 should be	Completed						pe	as an utopsy erformed? es 2 N	prior to death?	topsy findings available completion of cause of es 2 No
Vital Rechysician: The this certificate al director, page	To Be C	1 🗸 Yes 2 No	spital: 1 Inpatient 2		nt 3 DC	Other ₄	(Check only one) Nursing Home 5			
ivision of or Attending Phafter death. Director: After the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation		28b. Time of FOUND: 1249 hrs		3c. Injury at Work	No Subject o	n skate	board struck	
Division Huspital or Attent 24 hours after death tey filled in by the		3 Suicide 6 Could not be determined 29a. Certifier	(Specify) Local Stre	et			10545 Sv	n, State) veetbria	Pkwy, Silver	
Fo the Hu vithin 24 F Fo the Fu	edical	(Check only one) 2 Medical Examiner:	n: To the best of my knowled On the basis of examination a and manner stated							

31. Date filed (Month, Day, Year) 2006 State

30 Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD. Assistant Medical Examiner

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d Date signed (Month, Day, Year)

July 16, 2006

			For State Registrar	State of Marylar		artment of H		nd Mental H	ygiene Reg. No	ZUUD	24461
			Negistrar Necedent's Name (First, Middle, Last)					2. Date of D			3. Time of Death
	Physicia /Medic	an		llis			-	July	19,	2006	7:50 ^{a м}
	Examin		4a. Facility Name (If not institution, give st	treet and number)		4b. City, Town, or	Location of	Death	4c.	County of Death	
			Montgomery General			Olney				Montgome	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2 Hours		lirth Day, Year)	9. Birth	place (State or Foreign intry)
	Director		373-30-2458	M 2□F 82	Yrs.			June :	10, 1	924 Mic	higan
	P _		Usual Residence of Decedent	100 C	ity, Town or Lo	ention				· · ·	10d. Inside City Limits
	thow	_	10a. State 10b. County	100.0	ity, Town Of Lo	Cation					1 ☐ Yes 2 ☑ No
	e Me	Director	Maryland Montgome	ry	Silve	r Spring					
	th th or 26)ire	10e. Street and Number			10f. Zip Code			10g. Cit	tizen of What Cou	intry?
	th wi		3210 Norbeck Road,	#201		20906				USA	
	dea	Funeral	11. Marital Status	Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Decedent of H	ispanic Orig an, Mexican,	in? (Specify Yes or I Puerto Rican, etc.)	No-	 Race - Amer Black, White 	
9	or its	E	1 ☐ Never Married 2 🙀 Married	1 Yes 2 No		1 ☐ Yes 2K☐ No				Spec White	
ဗ္ဗ	ref.	d by	3 Widowed 4 Divorced	Year or Dates: 1945	-48						
21215-0036	within 72 hours after death with the Maryland ene. Then "naturel", or iteme 23a or 28a-f show to Madical Exertities regain be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup	during most	of working	16b. K	and of Business/li	ndustry
7	e. e.n	npidu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)		ŀ		
2	gien gerth	Son	12		Sal	esperson				ge Truck	Sales
B	al Hy	Be	17. Father's Name (First, Middle, Last)				18. Mother	's Name (First, Midd	lle, Maider	Sumame)	
<u>a</u>	uld b Went	ဥ	Albert Willis					erine Bail			
Maryland	and la		19a. Informant's Name/Relationship (Type	oe, Print)				r or Rural Route Nun			
Σ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: If item 27 is marked other than "naturel; or lieme 23a or 28a-1 show entry injuryer-giner traumatic event, the Madical Energiner relatible notified at any followed.		Inez Willis/ Wife				Road,	#201, Sil			
Baltimore,	S S S S S S S S S S S S S S S S S S S		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	amount from State	cemetery, cre-	osition (Name of matory or other place	ce)	Date	20c. L	ocation - City or T	own, State
Ĕ	Page High		4 Donation 5 Other (Specify)	51	. Paul	's Episco	pal '	July 22, 2006	Ches	tertown,	Maryland
Ħ	mit of the state o		21. Signature of Funeral Service License	e C	F	rancis A	ss et 5acuin	2006 ins Funera	al Ho	me Inc.	
m	9 5 E 9		AnneMari	etarker	5	00 Univer	sity :	Blvd, W, S	Silve	r Spring	, MD 20901
20			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dea	ath. Do not en	ter the mode of dyir	ng, such as	cardiac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final			11000	T ((A)/ 1100			Onset and Death
H	/Medical		disease or condition resulting in death)	CONGEST Due to (or as a conse	quence of):	HEHR	/r	MILURG	-		1 0000
	Examiner			TSCHEM	16	CARDI	6 M	YOPATH	14		IWEEK
16		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):		O Ivi	70111	-		
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
	be executed ician and buriaf-transit	Exa	resulting in death) Last	Due to (or as a conse	quence of):						
760,	ite be ex iysician iy burial	cail	l d								
68	ficat g phy is the										
Вох	deal certifica e attencing phi id foluse as th	M	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of preg		75				23d. Date of deli	very
ŏ	atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		□Ectopic pregnancy □ Other (specify) _	y 		- 1	Month	Day Year
o.	by the a	Physician/Med	9 Unknown	9□ Unknown							
صّ	thet		Part II. Other significant conditions con	tributing to death but not re	sulting in the	underlying cause giv	en in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?
of Vital Records,	The law requires thet the sie hes been signed by the bage 2 should be detache	d by	CORONARY HEAR	J DISCASO	= HI	N. D	M.	1[]Yes 2	Pro 3☐Pro	obably 4 [[Unknown
Ö	v requir been si shoufd	Completed	END STAGE RE					24a. W	as an	24b. Were au	topsy findings available
Re	The lav	m	au STHUE KEI	VHC DIS	CHIE	, 1500	CKCI	pe	rformed?	death?	completion of cause of
<u>=</u>			25. Was case referred to medical				00 81	1 Yes		o 1 ☐ Yes	2 □ No
₹	Physician: 1 this certificer ral director, p	Be	examiner?	lospital:		-t 307 004 Ott	200	of Death (Check on rsing Home 5 A		6 MOther (Spec	.6.1
of	Phys this ral di	. To	1 Yes 2 No	28a. Date of Injury	28b. Time			28d. Describ			.iiy)
S	ding l h. After funer	ion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury		rk?]Yes 2.∐!	No			
Si	ttsnd deatl ctor: / the	ca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, s	treet, factory, office		28f. Location	n (Street a	nd Number or Ru	ral Route Number,
Division	or At after of Direct in by	Certification:	4 ☐ Homicide determined	building, etc. (Spe	cify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or	Town, Stai	(6)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phys	sicien: To the best of my k	nowledge, dea	th occurred at the ti	me, date an	d place, and due to t	he cause(:	s) and manner as	stated.
	24 hos Fun etely	edical	(Check only 2 Medical Examination)	ner: On the basis of exami and manner stated.	nation and/or i	nvestigation, in my	opinion, dea	th occurred at the tim	e, date ar	nd place, and due	to the cause(s)
	of the	Me	29b. Signature and title of certifier	/		29c. Licens				ate signed (Month	
			> Muein	alvotein	, M.S	Do	05	7630	0	7-19-	2006
- 5	5+1		30. Name and address of person who co	ompleted cause of death (It	em 23a) (Type	Print)			1		
			Anuradha Arun, M	.D 10301 Geo	rgia Av	renue, #20	09. Si	lver Spri	ng, M	1d 20902	
10	St	ate	31. Date filed (Month, Day, Year)	32 Negistrar's Sig	nature	nells					
	Regist	rar	JUL 2 U 20	NO STATE .	so pop						

			For State Registrar	State of Maryland		artment of H			iene eg. No.	106	24462
· 5.	29).".	8	Decedent's Name (First, Middle, Last)					2. Date of Deal		Vana	3. Time of Death
	Physicia		LINDA	P	WIT	MER		JULY	19,	2006	4:00 P M
	/Medic Examin	4.	4a. Facility Name (If not institution, give st.	reet and number)		4b. City, Town, or	Location of Death	· · · · · · · · · · · · · · · · · · ·	4c. Cou	inty of Death	
			5722 Hildebrand	Road		Freder	ick		Fr	ederic	k
	Funeral	P=10	Social Security Number 6. Sex	7. Age (In yrs. la	•	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Births	place (State or Foreign
10.	Director	80	418-56-0606	M 2∑F 63	Yrs.	,		MAY 12,		A1ab	ama
	pu ×	}	Usual Residence of Decedent 10a, State 10b, County	10c City	, Town or Lo	cation					10d. Inside City Limits
	•ho	2									1 ☐ Yes 2X No
	he N	ect	Maryland Frede 10e. Street and Number	rick F	'reder	10f, Zip Code			l0a. Citizen	of What Cour	ntry?
	with a or	급		Road			704		Unite	_	•
	eath	era		2. Was Decedent Ever in U.S	6. 13.	Was Decedent of Hi f Yes, specify Cuba			14.	Race - Ameri	can Indian,
	fter d	Funeral Directo	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No				o Rican, etc.)		Black, White,	
21215-0036	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2🂢 No	Specify:		Spi	ecify: Wh	ite
Ò	2 ho	Completed	15. Decedent's Education (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Occupa	ation	kına	16b. Kind (of Business/In	dustry
21	thin 7	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)				
2	ygien ygien ier th	Con	9th		Ca	shier	40. 14-15-1-1-1-1-1			ry Sto	re
Maryland	ta! H d oth	Be	17. Father's Name (First, Middle, Last)	7 1				ne (First, Middle,			
<u> </u>	Men Merke	T ₀	Samuel	Jackson				efreese		ooks	- 0-4-1
<u>a</u>	2 sh and I • rr		19a. Informant's Name/Relationship (Typ			ng Address (Street a					
o o	1 and 4ealth em 27		Harry Witmer / H			2 Hildebra sition (Name of	and Rd.			1ary⊥ar on - City or To	
Baltimore,	or of		1 ☐ Burial 2 X Cremation 3 ☐ Re	emoval from State	metery, crei	matory or other plac	1				
₽	t. Part rtant		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			Cremator Name and Address					
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itema 23a or 28a-f show amy injury or other traumatic event, the Medical Exacts or must be notified at an ance.		21. Signature of Pulleral Service License	5		621 Oposs					21702
	12 - 44		23a. Part1. Exper the disease, or complic	ations that caused the death			*			ck, III	Approximate
7.1			shock of heart failure. List only one Immediate Cause (Final	e cause on each line.							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	End St	ge of	Emphy	sems_				yens
	Examiner			200 (0 (0) 20 2 00 (00 00	2 000 017.	,					
*		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	rendu of).						
	outed Id ansit	Examiner	Cause (Disease or injury that initiated events								
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8760,	ate be executed thysician and the burial-transit	Icai	d							_	
Ö	leath certifica attending ph I for use as t	Med	IF FEMALE:								
Вох	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy			23d	. Date of deliv Month	ery Day Year
0	it the death certificate by the attending phys tached for use as the	Physician/Med	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown	aun ol	Other (specify)			İ		
<u>a</u>	that the		Part II. Other significant conditions con-	tributing to death but not resu	alting in the u	inderlying cause give	en in Part I.	23e. Did to	bacco use	contribute to t	the cause of death?
Records,	200	d by						1 ₹ Д"Y	es 2 🗆 N	lo 3 🗆 Pro	bably 4 Unknown
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Re	The lavate has	F						autop		prior to co death? 1 \(\sum \text{Yes}	ompletion of cause of
Vital		Ö	25. Was case referred to medical		-		26. Place of Dea	1 ☐ Yes ath (Check only or		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
ĭ <u></u>	Phyaician: r this certific ral director,	0 B	examiner? 1 Tes 2 No	ospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Oth	er: 4 🗌 Nursing H	lome 5 🕅 Resid	lence 6	Other (Speci	fy)
οl	ding Ph h. After th funeral	T:U	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injur Wor	y at k?	28d. Describe h	ow injury o	ccurred	
<u>.</u>	Attending r death. ector: After by the fune	atic	2 Accident investigation			M 1	Yes 2 □ No				
Division	2 4 4 6	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify		reet, factory, office		28f. Location (S City or Tow		umber or Rur	al Route Number,
Ω	urs al		and the second second	initian Tarka bankatan Iran	winder don	the constraint of the board		and due to the		d ====================================	atatod
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the Funeral Direction of the Funer	Medical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examinate)	sician: To the best of my kno ner: On the basis of examinal and manner stated.	tion and/or in	ivestigation, in my o	pinion, death occu	irred at the time, o	date and pla	ice, and due t	to the cause(s)
	To the To the To the Comple	Me	29b. Signature and title of certifier	1		29c. Licens			29d. Date s	igned (Month,	Day, Year)
)	E		D4	3091		7-	20 06	5
-	10		30. Name and address of person who co	mpleted cause of death (Item	1 23a) (Type	Print)					
			Saeed Zaidi, 8	301 Toll House	, B1	dg E, Fre	derick, l	Maryland	2170	01	
	St. Regist	ate rar	31. Date filed (Month Car Year) 1 20	32. Engistrar's Signa							

ORIGINAL

		For State Registrar	State of Maryla		artment of rtificate of			ene	6 21.1.63
Physic		1. Decedent's Name (First, Middle, Las Frank Allen	Young				2. Date of Death Month July	Day Y	year 006 12:30 A ^M
/Medi Exami Funeral Director	ner	4a. Facility Name (If not institution, give 2500 Shelley Ci 5. Social Security Number 6. S	e street and number) Lrcle Unit 2	2-D s. last birthday) Yrs.		s Hours Min.	h 8. Date of Birth	4c. County of Fred (ear)	Death erick B. Birthplace (State or Foreign Country)
g		Usual Residence of Decedent 10a. State 10b. County Maryland Frederi	10c. 0	ity, Town or Lo	cation			2340	10d. Inside City Limits
ith the M or 28e-f	Olrect	10e. Street and Number		-	10f. Zip Code	•	10	g. Citizen of Wh	at Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Eventual eventual to inclined at mone.	by Funeral Director	2500 Shelley Circ 11. Marital Status 1 Never Married 28 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1	U.S. 13.	Was Decedent of f Yes, specify Cu	f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, White, etc. white
215-0036 thin 72 hours atl le. "naturat', or	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occ kind of work don DO NOT use reti	ne during most of wo	rking 1	6b. Kind of Busi	ness/industry
aryland 2121: should be filed within and Mental Hygiene. s marked othar then " umatic event, tre Me.	Com		2	Salesm	an	10 14-45-4-1-1		Automot	ive
and d be fill antal H sed off) Be	17. Father's Name (First, Middle, Last) Frank R. Youn					me (First, Middle, M a Greenawa	,	
Maryland Id 2 should be file Ith and Mental Hy Ith smarked oth treumatic evant	2	19a. Informant's Name/Relationship (<u> </u>			et and Number or R	ural Route Number,	City or Town, St	
h, Mg and 2 ealth a m 27 is		Mary Young - wif							nd 21702
More Pages 1 nent of Hu int: If iter		20a. Method of Disposition 1308 urial 2 Cremation 3 C	Theilioval Irolli State		sition (Name of natory or other p				ty or Town, State
Baltimore, permit. Pages 1a Department of Hei Important: If item any injury or othe once.		* 4 □ Donation 5 □ Other (Specification of Funeral Service (Specification of Funeral Service)	<u>" </u>	22		dress of Facility S	y 21, 2006 tauffer Fu ike, Frede	meral H	
Physician /Medical Examiner		231. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	equence of	er the mode of d	ying, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
18760, cate be executed physician and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):	with	net.	ilon		
Box 6 ath certifi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnar Other (specify)			23d. Date of Month	
rds, P.O. I quires that the de in signed by the a uld be detached t	by	Part II. Other significant conditions of	contributing to death but not re	esulting in the u	nderlying cause	given in Part I.		cco use contribi	ute to the cause of death?
The The page	Completed						24a. Was an autopsy perform	prio ed? dea	re autopsy findings available or to completion of cause of ath?
of Vital Physicien: Tribis certificate ral director, pe	Be	25. Was case referred to medical examiner?	Hospital:)thor	ath (Check only one)	
on of ding Phy a. After this funeral d	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 21 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time or Injury	f 28c. In	4 🗀 Hursing i	dome 5 lesider 28d. Describe hov	ce 6 Other	
Division or Attending after death. Diractor: After	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	B ORO Place of Injury . At	home, farm, str cify)			28f. Location (Stre City or Town,	et and Number State)	or Rural Route Number,
Divisic To the Hospitel or Attano within 24 hours after death To the Funeral Director: completely filled in by the	edical C		nysician: To the best of my ki niner: On the basis of examinand manner stated.						
To the within To the	Me	29b. Signature and title of pertifier) 4753.		d. Date signed (Month, Day, Year)
10		30. Name and address of person with Kimenah Le, M.D.	completed cause of death (It		Print)		e, Freder	ick, Mar	ryland 21702
Si	ate	31 Date filed (Month Day Year)	2006 32. registrar's Sig	nature	hadis				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 2006 7451 Mortimer Tul /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltmore Medical Cente University or Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1₽XM 2□ F 057160536 Yrs. 01/19/1922 NEW YORK Director Usual Residence of Decedent the Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23s or 28s-1 show other traumstic event, the Medical Examinar must be notified at DELAWARE PA 1 Yes 2 No ELKINS PARK Director 10g. Citizen of What Country? 10f. Zin Code 10e, Street and Number 19027 USA 26 TOWNSHIP LINE ROAD C41 death 1 Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1 2 Yes 2 No If Yes, Give Year or Dates: WWI 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Heelin and Mental Hygiene. Importent: if item 27 ie marked other then "naturel; or item any lajury or other traumatic event, the Medical Examine 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. TIWW WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WRITER & ACTOR ENTERTAINMENT 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM ALPER PAULINE (STEINBERG) ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19027 19a. Informant's Name/Relationship (Type, Print) 26 TOWNSHIP LINE ROAD C41 ELKINS PARK, RUTH R. ALPER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 8-1-2006 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses ROSEDALE, 1211 CHESACO AVENUE 21237 MD. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. proximate Interval Between Onset and Death Immediate Cause (Final 3 Hoves Physician THORACIC MASSIVE disease or condition resulting in death) TRAM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ettending physicien end for use es the burial-translt Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9 Unknown 9 I Unknown been signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 20 No certificate 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner?
1 □ Yes 2 □ No 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 1 Yes 2 No death 2 Accident after death Director: / 8 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Che Medi 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Sign and title of certifier 17584 MD

Registrar

State

30. Name and ad

31. Date filed (Month, Day, Year)

AUG 0 4 2006

ORIGINAL

South

Greek Street

22

32. Pegistrar's Signature

ess of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene (1)

		-	For State Registrar	State of Mary		tificate of l			g. No.	24400
	Physicia	~	1. Decedent's Name (First, Middle, Las	_	VHAN	1		2. Date of Death	Day Year	3. Time of Death 2 45 PM
	/Medic Examin	_	4a. Facility Name (If not institution, give				Location of Death		4c. County of Deat	h
			Summit Park			Catonsv			Baltimo	
	Funeral Director		5. Social Security Number 6. S. 225-50-4204 Usual Residence of Decedent	CILL OFFIC	95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 17,	Year) Co 1911 Vi	hplace (State or Foreign nuntry) rginia
	land	1	10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Mary I-f eh	ţċ	MD Baltim	ore	Catons	ville				1 ☐ Yes 2√ No
	h with the 23a or 28a st be not	al Direc	10e. Street and Number 1502 Frederick A	venue		10f. Zip Code 21	.228	10	g. Citizen of What Co USA	ountry?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 ie marked other than "naturel", or Items 23a or 28a-f ehow eny injury or other treumatic event, the Madical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 21 No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: b1	e, etc.
5-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Deces (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wor	king	6b. Kind of Business	Industry
121	han "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. i	nursing			vo1un	teer
	Hygie thert	ပိ	unk 17. Father's Name (First, Middle, Last)			unk		ne (First, Middle, M		unk
an	d be antal	To Be								
Maryland	shoul nd Me mark	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Number,	City or Town, State, a	Zip Code)
	alth a alth a 27 is		Teisha Brahan/grt				nd Stree	t Baltimo	re, MD 21	.229
Baltimore,	Pages 1 and of He ut. If item	-	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Specification of the control o	Removal from State	b. Place of Dispo cemetery, crer	osition (Name of matory or other plac	ce)	Date 2	0c. Location - City or	Town, State
Balti	permit. Depertm Imports eny Inju		21. Signatu Funeral Spryice Licer ROVAL d S	Wade, Direct		Raltimore	. MD 212	201	Baltimore	Street
			23a. Partl. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
A	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ahero Due to (or as a cor	ccle-	elic (Cardo	vascu f	n Due	Onset and Death
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Box	o death certif the attending hed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of print Diversity 2 4 Pregnant at time	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	4		23d. Date of de Month	livery Day Year
ds, P.O.	w requires thet the state of th	d by Ph	Part II. Other significant conditions of	contributing to death but no	t resulting in the u	inderlying cause giv	ven in Part I.	23e. Did tob		o the cause of death?
Division of Vital Records,	aw as b 2 sl	Completed by						24a. Was an autopsy perform	prior to	utopsy findings avaitable completion of cause of
alF	Thate are	e Cor	05 W	1			00 Place -/ C	perform 1 Yes 2		2 □ No
Κ		m	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatie	nt 3□ DOA O#	100	ath (Check only one	nce 6 ∐Other (Spe	rcifu)
on of	D et ec	tion: To	27. Manner of Death Naturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time o	of 28c. Injui		28d. Describe hor		,,
Divisi	or Attending effer death. I Director: Affe d in by the fune	Certification:	3 Suicide 6 Could not be determined			reet, factory, office		28f. Location (Str City or Town	eet and Number or R , State)	ural Route Number,
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fo	Medical C		hysician: To the best of my miner: On the basis of exa and manner stated.	mination and/or in	nvestigation, in my	ppinion, death occu	urred at the time, da	ite and place, and du	
	To th withir To th	M	29b. Signature and title of certifier	1000	n		se number / 58 /	2]	ed. Date signed (Mon	
			30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print) Ain 57	reet	- 2/1	36	
	St Regist	ate rar	31. Date filed (Month, Dey, Year) AUG 0 4 20		Signature	all'				

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	Physici		Decedent's Name (First, Middle, Last) David	Br	own			1	2. Date of Dear Month	D	006 Year	3. Time of Death 3:15а м
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, T	own, or L	ocation of	Death			ity of Death	
10	Examin	er	6609 Ellsmere Place Apt. B			rkvi.					ltimo	
	Funeral	25 (2)	5. Social Security Number 6. Sex 7. Age (In yrs. la:	st birthday)	If Under 1	Year	If Under 2		B. Date of Birth (Month, Day,			place (State or Foreign intry)
	Director		215-78-8381 ^{™ 2□F} 48	Yrs.	Months	Days	Hours	Min.	4-17-	58	Cou	Va.
	₽ .		Usual Residence of Decedent									
	show	_		Town or Lo								10d. Inside City Limits 1 X Yes 2 ☐ No
	Ba-f	cto	Md. Baltimore	Park					···			
	or 2	Dire	10e. Street and Number		10f. Zip (00de 21234	1		1	0g. Citizen o	if What Cou ISA	intry?
	ath v 23s	E .	6609 Ellsmere Place Apt. B	10					4. Van an Na			inne Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene importants: If item 27 is marked other then "neturel; or items 23a or 28a-f show simportants: If item 27 is marked other then "neturel; or items 23a or 28a-f show air injury or other traumatic event, ite Medical Examinal must be notified at an once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 2 Divorced		Was Decede If Yes, specif 1 Yes 2	fy Cuban	panic Orig , Mexican, Specify:	jin? (Spec , Puerto R	ify Yes or No- ican, etc.)	В	ace - Ameri lack, White cify: B1	, etc.
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	Hygothe other	Be C	17. Father's Name (First, Middle, Last)						(First, Middle, I	Maiden Sumi	ame)	
Maryland	Menta Menta arked atic ev	To B	Samuel Lee		n, Sr			rgin:				rson
Jar	2 sho	1	19a. Informant's Name/Relationship (Type, Print)						Route Number		m, State, Zi 21239	
	and lealth m 27	1 }	Nathaniel Brown Brother		winic sition (Name		κα.,		imore,	20c. Location		
016	t of H if ite or ot		N Burial 2 □ Cremation 3 □ Removal from State	netery, crei	matory or oth	her place)	8-5-0		Lansdo		
Ħ	t. Pa ntmen ntent:		4 Donation 5 Control (opsetty)		n Cem		-4 5 1115		_			
Baltimore,	Depermine Depermine Important ir mportant		21. Signature of Funeral Service Licensee		2. Name and March	_	_		Balti 1101 E	more, . Nort		21202
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rds	quires n sign			<u> </u>					1 🗆 Y	es 2 No	3 Pro	bably 4 Unknown
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Vital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	eron-c			26. Place	of Death	Check only or			
†	Physician: this certific ral director,	Tof		R/Outpatie	nt 3 🗆 DO	A Other	. 4 🗆 Nu	rsing Hom	e 5 Resid	ence 6 🗆 C	Other (Spec	ify)
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sio	eath. or: A	cat	2 Accident investigation		М		es 2 🔲					
Division	or Att	Certification:	4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, st	reet, factory,	, office		2	8f. Location (S City or Tow		mber or Rui	ral Route Number,
	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my know and manner stated.	rledge, deat on and/or in	th occurred anvestigation,	at the time in my opi	e, date and inion, deat	d place, a	nd due to the c d at the time, d	ause(s) and late and plac	manner as e, and due	stated. to the cause(s)
	o the o the omple	Me	29b. Signature and title of certifier		29c.	License	number		2	9d. Date sign	ned (Month	, Day, Year)
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7	1		30. Name and address of person who completed cause of death (Item	23a) (Tyne	Print)		525 1-d		1	Tugue	>1 61	
	6		David J. Namay us 560	1 Coc	h las	u B	1-cl.	B	altims.	re, MD	212	39
	St: Regist	ate	31. Date filed (Month, Day, Year) AUG 0 4 2006 32. Begistrar's Signatu									
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			For State Registrar	State of Maryland / Dep.	artment of Health and I	Mental Hygier	2006	24467	
	Physicia /Medic	al	Decedent's Name (First, Middle, Last) O S EPV Aa. Facility Name (If not institution, give stress.)		ROOKS 4b. City, Town, or Location of Deat	2. Date of Death Month	Day Year 2006 C. County ol Death	3. Time of Death	
	Examin Funeral Director	er	NOCT Hu 5. Social Security Number 6. Sex		RANGE STATE OF THE	8. Date of Birth	BACTI	ace (State or Foreign	
Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23s or 28s-f show eny injury or other treumatic event. The Medical Examinat must be notified at 900s.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. Street and Number 2525 11. Marital Status 1 Never Married 2 Married 3 Nide Middle Americal Secondary (0-12) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type County	Amped Forces? I Mayes 2 DNo If Yes, Give Year or Dates: Ition completed) College (1-4or 5+) 19b. Maili 20b. Place of Disp. cemetery, cre Carries Converses C	101. Zip Code 2/2/5 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 □ Yes 2 (No Specify: dent's Usual Occupation kind of work done during most of wo DO NOT use retired) 18. Mother's Nat Refu	pecify Yes or No- o Rican, etc.) rking 16b. rking Grad Route Number, Cit	Citizen of What Count USA 14. Race - America Black, White, e Specify: Black Kind of Business/Ind MTA Jen Sumame) COTT B	an Indian, atc. ACK TUSTRY POOKS Code) 2 1043 why Md why Md LIS Md 2 1 2 1 6	
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Division of Vital I	Attending Physicien: death. ictor: After this certifice by the funeral director.	Certification: To Be Co	27. Marier of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	spital: 1 Inpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, farm, st	ont 3 DOA Other: 4 Nursing H of 28c. Injury at Work? M 1 Yes 2 No	ath Check only one lome 5 Residence 28d. Describe how in 28f. Location (Street	No 1 ☐ Yes : 6 ☐ Other (Specify, niury occurred and Number or Rural		
Ö	To the Hospital or within 24 hours affer within 24 hours affer To the Funerel Direction completely filled in E	edicai	29a. Certifier 1 Certifying Physi	building, etc. (Specify) cian: To the best of my knowledge, deal r: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occu	irred at the time, date a	o(s) and manner as sta and place, and due to	the cause(s)	
	To the complex	M	29b. Signature and title of certifier Multiple 1995 30. Name and address of person who com				Date signed (Month, D VVY 31 WSTOWN M	**	
	1		MICHAEL ROTH	KIN, MB 5401	OLD LOURT RO	to RAMOA	custom 1	JAM MAND S	

State Registrar

31. Date liled (Month, Day, Year)

32. Registrar's Signature

			For State Registrar	State of Maryla	•	artment of rtificate of			giene Reg. No. 006	24463
10.	Physici	an	1. Decedent's Name (First, Middle, Last)		-			2. Date of Dea Month	Day Year	3. Time of Death
	/Medic	al	Gertrude S. Brow 4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of D	July 3	30, 2006 4c. County of Death	8:40 PM [™]
	Examin	ei	Homewood Nursing			William	sport		Washing	ton
	Funeral		Social Security Number 6. Sex 1	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Yea Months Days	r If Under 24 s Hours M	Min. (Month, Da	h 9. Birth	place (State or Foreign ntry)
	Director		217-28-5563 Usual Residence of Decedent	88				Oct 9,	1917 Mary	Land
	anyian ehow	_	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-f	ecto	MD Washing 10e. Street and Number	ton	Hagers	10f. Zip Code			10g. Citizen of What Cou	
	h with	ai Di	16505 Virginia Av	enue C-171			2174)	US	-
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 le marked other than "natural; or Items 23e or 28e-1 ehow other traumatic event, the Modical Examinating to notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1 XI Yes 2 □ No If Yes, Give Year or Dates: 19		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2X N		? (Specify Yes or No- uerto Rican, etc.)	Canaibu	
21215-0036	n 72 hou "natura balical E	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occ kind of work don DO NOT use retii	e during most of	f working	16b. Kind of Business/fr	dustry
212	e filed within al Hygiene. I other than " vent, the Man	Omp	Elementary/Secondary (0-12) 12 4	College (1-4or 5+)		nurse			healthcar	·e
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Maryland	should be nd Mental marked o umatic eve	ို	Simon Leslie Sh 19a. Informant's Name/Relationship (Ty)		19h Maili	na Address (Stree		ca Gertruc	de Davis er, City or Town, State, Zi,	2 Code)
Ma	nd 2 salth an 27 le		Kathleen Lucas/d					d Hagerst		
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☒ Donation 5 ☐ Other (Specify)			osition (Name of matory or other p	lace)	Date	20c. Location - City or T	own, State
Balti	permit. Pag Department Importent: I any njury o		21. Signature of Funeral Strvice Licenses	Vade precto	or	Name and Add State A Baltimo	ress of Facility natomy 1 re, MD	Board 655 21201	W. Baltimor	e Street
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	gned gned se de	þ	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	inderlying cause o	given in Part I.	23e. Did to	obacco use contribute to	he cause of death?
I Records,	The ate h page	Completed	Avial tession	latoir						opsy findings available impletion of cause of
Vital	Physician: This certifical	Be	25. Was case referred to medical examiner?	lospital:		- 10		Death Check only o		
of	fler fler	ıtlon: To	1 Yes 2 No 27. Manner of leath 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 € 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. In	Nursir	28d. Describe h	dence 6 Other (Speci now injury occurred	(y)
Division	el or Attendi s after death. sl Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec		reet, factory, offic	9	28f. Location (S City or Tov	Street and Number or Rur vn, State)	al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Directorpletely filled in b	Medical (29a. Certifier 1 Certifying Phys (Check only 2 Medical Examination)	sicien: To the best of my kiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the vestigation, in my	time, date and p opinion, death o	place, and due to the occurred at the time,	cause(s) and manner as s date and place, and due t	stated. o the cause(s)
)	To the within 2 To the complete	Σ	29b. Signature and title of certifier			29c. Lice	268	3	Duly 31	•
	Sta Regist		30 Name and address progress who co	mpleted cause of death (It	NEKE	Print)	ne l	Hagest	an MD	21742

		_ For	State of Ma	ryland / Dep	artme	nt of He	ealth and				24469
		1 - State Registrar		Ce	rtifica	te of D	Death		Reg. No.	.000	4400
Dhuo	iaiaa	Decedent's Name (First, Middle,	Last)					2. Date of De Month	ath Day	Year	3. Time of Death
Phys /Me	dical	BUNDIN AUGIN DIN	ler					8	2	06	11:58 WM
Exar	niner	4a. Facility Name (If not institution,	give street and number)		4b. Cit	y, Town, or	Location of Deat	h		County of Death	
		Franklin Square			Y	OSE			15	saltin	
Funer			3. Sex 7. Age	(In yrs. last birthday	Month:	er 1 Year s Days	If Under 24 Hrs Hours Min.		th ay, Year)	9. Birthr	place (State or Foreign
Direct	or	216–30–8194 Usual Residence of Decedent		71 Yrs.				NOV. 2.	3,193	4 Mary	Land
land ow	65	10a. State 10b. County		10c. City, Town or L	ocation						Od. Inside City Limits
Mary Feh	į	Maryland Baltim	ore	Middle R	iver						1 ☐ Yes 2√0XNo
r 28s	Director	10e. Street and Number				ip Code			10g. Citiz	en of What Cou	ntry?
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within the control of		Elementary/Secondary (0-12)	College (1-4or 5+	Press		use remed)			Dri	nting	
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Vian Duid be Mentai Arked o	TO Be	George Edward	Butler				Nellie	Louise	Gil	1	
Shoul Mark	-	19a. Informant's Name/Relationsh	p (Type, Print)	19b. Mail	ing Addre			ural Route Numb			Code)
M62 lith al 27 is		Joan Eloise But	ler (Wife)								land 21220
Baitimore, Maryiar permit. Peges 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic ex		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (N	ame of	1-1	Date		ation - City or To	
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Battimore , permit. Peges 1 ar Department of Hea important: if item any injury or other	Ŕ	21. Signature of Furnish Service I		1 2	2 Name	and Address	of Facility				
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		23a. Partt. Cale the disease, or o shock, or heart failure. List o	complications that caused in	the death. Do not er	nter the m	ode of dying	, such as cardia	c or respiratory a	rrest,	A, Mary	Approximate Interval Between
Pnysicia	10	Immediate Cause (Final	ny one cause on each line	K1 -							Onset and Death
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axi.	,	30. Name and address of person v	tho completed cause of de	eath (Item 23a) (Tyne	, Print)	DA	TX	U	0 /	0100)
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		For State Registrar	State of M	Maryland		irtment <i>tificate</i>			ina M	-	giene Reg. No.	200	6	2447
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Examin	er	4a. Facility Name (If not institution, Stella Maris		er)		4b. City, T Lu		rvi 1				County of Balt		ore
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ems 2	nera	11. Marital Status	12. Was Deceder	nt Ever in U.S	S. 13. V	Vas Decede	ent of Hisp	panic Orig	gin? (Spe	cify Yes or No Rican, etc.))-	14. Race -	Americ White,	
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State Registrar DHMH 17 Rev 1/2001 DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

AUG 0 4 2006

TIMONIUM,MD 21093

2300 DULANEY VALLEY RD.

2300 DULANEY VALLEY RD.

		1 - For State Registrar	State of Marylan	d / Department of Health and N Certificate of Death	lental Hygiene Reg. No	/1111h / 1111 / 1
Physi		1. Decedent's Name (First, Middle, Last)	BISHOR	2. Date of Death Month Day	y Year 3. Time of Death
/Med Exam Funera Directo	niner al	2117 797 916 1	in Cente	Ab. City, Town, or Location of Death Asst birthday) If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	County of Death 9. Birtholace (State or Foreign
Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Mdi Baut	mure 10c. City	y, Town or Location Woodlawn		10d. Inside City Limits 1 ☐√es 2 ☐ No
death with the Maryland ims 23a or 28a-f show if must be notitied at	ai Director	10e. Street and Number Summe	erfield Rd	10f. Zip Code Z 1207	10g. Cit	izen of What Country? USA
Iryland 21215-0036 should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other than "nature!", or items 23a or 28a-f show matic event, the Medical Examinar marks to notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Décedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	.S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0 d within 72 ho giene. or than "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use relired), W	ing 16b. K	ind of Business/Industry
aryland 2 should be filed and Mental Hygic marked other	To Be C	17. Father's Name (First, Middle, Last)	1 Irb	18. Mother's Nam Eliza	e (First, Middle, Maiden Leth E	Sumame)
Ma nd 2 st alth ar 27 is		19a. Informant's Name/Relationsh (Ty Abraham Irb (20a. Method of Disposition	y-concin	19b. Mailing Address (Street and Number or Run 9 Summer Circle Rollage of Disposition (Name of	1. Balto.	md. 21207
Page nent o		1 Squrial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature Fun al Service Licen	Removal from State	punsible Vet. 8	4-06 CN	visite, md
Balti permit. Departm Importa		Mul	I frut	22. Name and Address of Facility 27 Gary P. march Fu h. Do not enter the mode of dying, such as cardiac	neral Hone	Balto, md. 2,229
Physicia /Medica	ıl	shock, of heart failure. List only of Immediate Cause (Final disease of condition resulting in death)	ne cause on each line. a	slemic Shock		Interval Between Onset and Death
8760, A sate be executed monysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Upper Due to for as a consequence Due to for as a consequence Expende	Meces disease	/ driodeno	YEARS
Division of Vital Records, P.O. Box 61 to the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funerei Director: After this certificate has been signed by the ettending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of do 9 Unknown	I death 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
cords, P. w requires that been signed b should be deta	ρ	Part II. Other significant conditions con	ntributing to death but not rest	ulting in the underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death? ☐ No 3 ☐ Probably 4 ☐ Unknown
Vital Reco sician: The law re s certificete has be- lirector, page 2 sho	Completed	CVA			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vita reician: s certific firector,	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐	100	h <i>(Check only one)</i> me 5 🗆 Residence	6 Other (Second)
Division of Vital Records, to the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be completely filled in by the funeral director.	Certification; T	27. Manney Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		28d. Describe how injur	
Divis		4 Homicide determined	building, etc. (Specify	y)	City or Town, State	
To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my knoiner: On the basis of examinal and manner stated.	wledge, death occurred at the time, date and place, tion and/or investigation, in my opinion, death occurr	and due to the cause(s) red at the time, date and	and manner as stated. I place, and due to the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier	rdo On A	29c. License number 032717	8/	e signed (Month, Day, Year)
3		30. Name and address of person who confidence of the confidence of	A. OE		N MC	DR 21204
Regi		AUG 0 4 20	32. Ragistrar's Signa	B. Joseph		
DHMH 17 Rev	./2001			ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [

			For State Registrar	State of Maryland / [Department of H Certificate of I		ental Hygier		24472
	Physici /Medic		1, Decedent's Name (First, Middle, Las	repeda			2. Date of Death Month	Day Year	3. Time of Death 8:15 M
	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or	Location of Death	2	4c. County of Death	
Ī	Funeral Director		27-72 1361		thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day Yea	9. Birth	place (State or Foreign ntry)
	within 72 hours after death with the Maryland ene. than 'natural', or flems 23a or 28a-1 show fra Medical Examinat must be notified at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	11.				10d. Inside City Limits 1 □ Yes 2 □ No
	vith the h	Funerai Directo	10e. Street and Number	1/1	10f. Zip Code	0.6	10g. (Citizen of What Cour	
	ems 23s	inerai	16 19 KOIII 9	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	ispanic Origin? (Spec	ify Yes or No-	14. Race - Americ Black, White,	
5-0036	e filed within 72 hours after death with the Marylan al Hyglene. I other than "natural", or Items 23e or 28e-1 show vent, the Medical Examinar must be notified at	þ	Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:	, 5.65.,	Specify: Bl	ack
215-0	hin 72 h	Completed	15. Decedent's Edi (Specify only highest grad Elementag/Segorgtary (0-12)	ucation 16a. de completed) Coilege (1-4or 5+)	Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired	during most of working	16b.	Kind of Business/In	dustry
d 21	filed Hygi other ent, I	Be Con	17. Father's Name (First, Middle, Last)	K	eceiving	18. Mother's Name (First, Middle, Maide	en Sumame)	ruice
ryland	Ments Ments arked	ToB	Estabas Ce	peda	Mailing Address (Street	Helen	Bish		Codel
, mary	nd 2 salth ar 27 is r trau	1	Jolanda Cer	seda 18	319 Rollin	na View	Ave, I	Balto MI	21236
altimore,	Pages 1 a nent of Hez int: If item iry or otha		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,		Disposition (Name of y, crematory or other place	Mator 81	11/06 3	Location - City or To	own, State
Balt	permit. Pa Departmen Important: any injury.		21. Signature of Funeral Service Licens	Ma1363	22 Name and Address	ss of Factor	ices f	A. 16.1	17 21279
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. Do r	not enter the mode of dying	g, such as cardiac or	respiratory arrest,	y strongly	Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to fr as a consequence of	of):				
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68/6 0	ficate be physicia s the bur	Jicai		d					
. Box	death certificate be executed to attending physician and ad for use as the burial-transi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	ory Day Year
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ecords	neen poul						1 🗆 Yes		
r	The la ate has page 2	Completed					24a. Was an autopsy performed?	prior to cor death?	psy findings available inpletion of cause of
VITAI H	ysician: The la is certificate ha director, page 2	o Be (25. Was case referred to medical examiner?	Hospital:	Othe	26. Place of Death (
IO UOI	ding Phy J. After this funeral d	-	1 Yes 2 No ' 27. Mann f Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. T In Day Year) 28b. T In Day Year	ime of 28c. Injury	at 28	d. Describe how inj	6 □Other (Specify ury occurred	/)
DIVISION	after death after death Diractor: d in by the	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28	f. Location (Street a City or Town, Sta	and Number or Rura te)	l Route Number,
	To the Hospital or At within 24 hours after C Ko the Funaral Dirac completely filled in by	edicai C	29a. Certifier Certifying Phy	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the time for investigation, in my op	ne, date and place, and pinion, death occurred	d due to the cause(at the time, date a	s) and manner as st nd place, and due to	ated. the cause(s)
	Within complete	Me	29b. Signature and title of certifier		29c. License	number	29d. D	ate signed (Month, I	
r			30. Name and address of person who co	ompleted cause of death (Item 23a) (Type, Print)	ナリレブ	+	131/06	
9			2 - Meuhet 31. Date filed (Month, Day, Year)	- VISIR Della	double V	4D 21	222		
	Sta Registr			32. Registrar's Signature	Sperte				

			1 - For State Registrar	State	of Maryla	and / Depa	artment rtificate					giene Reg. No.	2006	24473
	Physici /Medic		1. Decedent's Name (First, Middle, Robert D. Coope	•							2. Date of Dea	Day	Yeer	3. Time of Death 3:10 a M
	Examin		4a. Fecility Name (If not institution,	•	um <i>ber)</i>		4b. City, 7		Location of	of Death	Aug. 1	4c. C	County of Dea	
Ε			31 Township Ro	a. S. Sex	7 Age //p v	rs. last birthday)	If Under		dalk If Under	24 Hrs.	9 Date of Birth		altimo	
	Funeral Director		230- 24- 2071	1(XM 2□F	77	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da Sept. 2	6,192	28 W. Y	thplace (State or Foreign ountry)
	pu k		Usuel Residence of Decedent 10a. State 10b. County		100	City, Town or Lo	noation						1 11	10d. Inside City Limits
	Maryla a-f eho	tor		imore	100.	Dundal	k							1 ☐ Yes 2X No
	death with the Maryland ime 23s or 28s-f show	Funeral Director	10e. Street and Number 31 Township Rd.	,			10f. Zip	^{Code} 212	22				en of What C	ountry?
2-0036	172 hours after death with the Marylan "naturel", or Iteme 23e or 28e-1 ehow Idical Examinar must be notilied at	by	11. Marital Status 1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed F	2 ∐ No aive	i	Was Decede If Yes, special		spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto I	ocify Yes or No Rican, etc.)		4. Race - Am Black, Whi Specify: W	
, n	72 ho	eted	15. Decedent's (Specify only highest		()	16a. Dece	dent's Usual kind of work DO NOT use	l Occupa	ation during mos	t of workir	ng	16b. Kin	d of Business	/Industry
717	d within 72 piene. r then "ne	Completed	Elementary/Secondary (0-12) 12 yrs.	T	(1-4or 5+)		lice (and the state of t	Bal	timore	County
land	s 1 and 2 should be filed if Health and Mental Hyg Item 27 is marked othe other traumatic event,	To Be C	17. Father's Name (First, Middle, L Robert L. Coop							er's Name al Wh	(First, Middle, ite	Maiden S	Sumame)	
Mary	id 2 shouth and N		19a. Informant's Name/Relationsh Gloria Cooper	ip (Type, Print) Will	fe	1	-				Route Number			Zip Code)
more,	Peges 1 an nent of Heal nt: If Item? iry or other		20a. Method of Disposition 1 \(\overline{\text{DS}}\) Burial 2 \(\overline{\text{Cremation}}\) Cther (Sp			o. Place of Dispo cemetery, crei Oak IAW	osition (Nam matory or oth n Cem	e of her plac	e)	Aug.	8 2006		ation - City or	
Dalt	permit. Peges Department of Important: If it eny injury or o		21. Signature of Funeral Service	Second Second	-	20	Name and onnel	Addres Ly F	s of Facilit	il Ho	me Of I Rd. 212	ounda 222	lk	
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VITA	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				▲ Othe	-		(Check only o			
6	Phy this rald	To To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	e of Injury	ER/Outpatier		A Bc. Injury	4 🗆 140		ne 5 Resid			acify)
0	Attending P r death. sctor: After i by the funers	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investig	ation	nth, Day Year) Injury	М		<br Yes 2 □	No				
UIVISION	after de Directo Jin by th	Certification:	3 Suicide 6 Could n 4 Homicide determin	and 286. Plac	ce of Injury - A ding, etc. (Spe	t home, farm, str ecify)	reet, factory,	office		2	28f. Location (S City or Tox		Number or R	lural Route Number,
	To the Hospital or Attank within 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the xaminer: On the and ma	ne best of my libasis of examiner stated.	knowledge, deat ination and/or in	h occurred a vestigation,	at the tim	ne, date an pinion, dea	d place, a	and due to the o	cause(s) a date and p	and manner a place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Dun A1	tensi	NC	-		number	2		A	signed (Mon	
7	8		30. Name and address of person v	no completed ca	use of death (I	tem 23a) (Type,	Print)		7 (()					
			31. Date filed (Month, Day, Year)	up Rtz	Registrar's Si		12 1	ku)	unc	X R	el 2	126	£	
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23a per doc 2858 8-4-06 vt. State of Maryland 7 Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Arthur Francis Carven III July 4:42 P M 27, 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 432 Dellcrest Drive Forest Hill Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 **№** 2 □ F Yrs. Director 222-36-0279 54 11,1952 Massachusetts Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show other traumatic avant, the Medical Examiner must be notified at Director 1 ☐ Yes 217 No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 432 Dellcrest Drive Itams 23a 21050 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced White "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Workmans Comp Commissioner State of Maryland 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be be f Arthur Francis Carven, Jr. Pages 1 and 2 should be nent of Health and Ment Ann Veronica Sheehan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth M. Carven/ Wife 432 Dellcrest Drive, Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or *4 ☐ Donation 5 ☐ Other (Specify) St. Francis de Sales: 8-1-06 Abingdon, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. any 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastatic pancreas cancer /Medical Due to (or as a consequence of): Examiner 2006 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 1 Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) P 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 🗌 Pending Injury 1 TYes 2 TNo s after death. investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. To the I 29c. License number 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 1)53070 30. Name and address person who completed cause of death (Item 23a) (Type, Print) D . Daniel, Laheru

State

Registrar

BaH, MI 2123

32 Registrar's Signature

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AUG 0 4 2006

31. Date filed (Month, Day, Year)

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Sta Registr		31. Date filed (Month, Day, Year) AUG 0 4		egistrar's Signa	ature	ack!	•							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend item#10c,10f,19b,perFh,g858,8/4/06 Through the Registrar Registrar Registrar Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 18 2006 12:30 AM MARK JAMES DAVIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore City
If Under 1 Year If Under 24 Hrs. UNION MEMORIAL HOSPITAL N/A8. Date of Birth (Month, Day, Year) Oct 12, 1956 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours Min 1⊠M 2□F 49 Yrs Pennsylvania Director 174-48-9224 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Itam 27 is marked other than "netural", or Itame 23a or 28a-f show other traumatic event, the Madical Examinational be notified at 1 ☐ Yes 2X No Director Pennsylvania West Newton Belle Vernon Westmoreland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15012 410 Park View Road 15089 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "netural", or iter eny Injury or other treumatic event, the Medical Examinations. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Retail Industry 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James J. Davis Kathleen Hough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Belle Vernon, PA 15012 410 Park View Road, (Wife) Mrs. Linda Davis 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 15012 4 ☐ Donation 5 ☐ Other (Specify) Mon Valley Crem. Serv. Aug 1, 2006 Belle Vernon, PA 21. Signa / 1 of Funy al S ... Licens awron Martin D. Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 10 to 10 t Approximate Interval Between Onset and Death Immediate Cause (Final Inflammatory Response Syndrome Priysician 1 week disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated more) Examine Aspiration Pneumonia burial-fran that initiated events resulting in death) Last and or as a consequence of): the eftending physician Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ŏ Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? À 1 TYes 2 No 3 Probably Completed Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No To the Hospital or Attending Physician: "within 24 hours after death."

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۴ 2 ER/Outpatient 3 DOA Director: After the in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Igor Belyansky 222943

Registrar

State

Union MEMorial Hospital MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IGOR BELYANSKY

2006

31. Date filed (Month, Day, Year)

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		1- For Amend item#3,4 Registrar		of Marylar 858,8/29/	d / Depa Ce	artment rtificate	of H	ealth and Death	н	eg. No:-	06	24477
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Funera		,	3.Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 61	last birthday) Yrs.	If Under 1	Days	If Under 24 Hrs Hours Min	. (Month, Day	Year)	9. Birth	nplace (State or Foreign untry)
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To tha within 2 To tha complet	Me	29b. Signature and title of certifier	Ymo	enp in	0	29c.		DOO 3			gned (Month), Day, Year)
3		30. Name and address of person was Susan Ginsberg	, MD; 1	06 Irvi	ng Stre	eet NW	Sı	ite 418	South; V	Vashin	igton,	DC 20010
S Regis	tate trar	31. Date filed (Month, Day, Year) AUG 0 4 2	2006	Registrar's Sign	alure Ap	ade						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 11 5 Certificate of Death 2. Date of Death 3 Time of Death 1 Decedent's Name (First, Middle, Last) July 30 2006 11:05 AM Disney Sr. Donald Bruce 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Arnold Future Care Chesapeake If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, May 23, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 ☑ M 2 ☐ F 79 Yrs 220-22-6051 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Maryland Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21122 8358 Country Life Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BGF Supervisor 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Disney Jennie Brown Arthur В. С. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8358 Country Life Road, Pasadena, MD 21122 Dorothy M. Disney (spouse) Date 03 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Glen Haven Cemetery Glen Burnie, Maryland 4 □Donation 5 □Other (Specify) 2006 21. Signature of Funeral Service Licentee Stallings Funeral Home, P.A.

Physician /Medical

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a State

Director

Funera

þ

Completed

Funeral

Director

Examiner Examine physician and state is the buriat-transit

IF FEMALE:

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

Physician/Medical

à

Completed

Certification:

Medical

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of) Due to (or as a consequence of):

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only on cause on each line.

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

9 Unknown

3 Ectopic pregnancy 5 Other (specify)

obstructive

23d. Date of delivery

23e. Did tobacco use contribute to the sause of death?

3 robebly

Year

4 DUnknown

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy performed 20

3111 Mountain Road. Pasadena. MD 21122

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 10 27. Mann of Death 28b. Time of 28d. Describe how injury occurred Injury at Work?

28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

М 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jennifer Riedinger, M.D. 8601 Veterans Hwy. Suite #204, Millersville, MD 21108 31. Date filed (Month, Day, Year)

State Registrar

2006



To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc 8858 8-4-06 vt. State of Maryland / Department of Health and Mental Hygiene 2 0 0 5

24479

	F	uner	a
	D	irect	oı
altimore, Maryland 21215-0036	mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland partment of Haalth and Martial Hydiana.	ordent: If tem 27 is marked other than "natural", or items 23s or 28s-1 show ordent: If tem 27 is marked other than "natural", or other traumatic event, the Modical Examinar must be notified at	

			1 - State Registrar		Cer	tificate of Death	R	eg. No.	
	Physici	an	Decedent's Name (First, Middle, Last)	Phyllis Pric	e Do	rsey	2. Date of Deat Month	Day Year	3. Time of Death
,	/Medic		THALLIS			TRICE	JULY	21 200	
	Examin	er	4a. Facility Name (If not institution, give st THE JOHNS HO	PKINS HOSE	DITAL	4b. City, Town, or Location of Death BALTIMORE	,	4c. County of Dea	th A
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year If Under 24 Hrs.	,	9. Bir	thplace (State or Foreign
	Director	4	213-62-6738 10	M 200 53	Yrs.	Months Days Hours Min.	Pelo: 13,	1952 V	irginia
	D		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Loc	cation			10d. Inside City Limits
	Aaryla febo	ō		1A	13	THE AND ALS)		1 Yes 2 □ No
	r 28a-	Director	10e. Street and Number		2.	10f. Zip Code	1	0g. Citizen of What Co	ountry?
	death with the Maryland me 23a or 28a-1 ehow rmest be notified at		3447 Old	Fredorick	Rd.	2122	9	US,	4
	r deal	Funeral	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit	
36	rs afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ∰No If Yes, Give Year or Dates:	1	☐ Yes 2☐ No Specify:		Specify: £	Black
5-003	be filed within 72 hours after death with the Marylar lat Hygiene. Id other than "naturel", or Iteme 23a or 28a-f ehow event, the Madical Examinat must be notified at	ted t	15. Decedent's Educ	ation		ent's Usual Occupation		16b. Kind of Business	/Industry
215	thin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done during most of work OO NOT use retired)	king	Cator	1 House
2	filed wi Hygien other th		10th	NIA		Cook			
Maryland		ro Be	17. Father's Name (First, Middle, Last)	Carter		Rebec	ne (First, Middle, M	Dates	
<u>a</u>	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Typ	1 /	19b. Mailin	g Address (Street and Number or Ru	_		Zip Code)
	s 1 and f Health Item 27 other tr		Richard Horse	y-husbard	344	7 Old Frederich			21229
ğ	0 0 <u></u>		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re	moval from State	netery, crem	atory or other place)		20c. Location - City or	il and.
altimore,			4 □ Donation 5 □ Other (Specify) 21. Signature of Fineral Sarvice Light Fee		nitz	Name and Address Facility 27			
ñ	permit. Departr Importe any in		How // 1/ for	1	6	am P. march	Funeral t	tone Balto	ind,21229
			23a. Part I. Enter the disease, or complic shock or heart failure. List only one	ations that caused the death.	Do not ente	or the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
)	Physician		Immediate Cause (Final disease or condition	PNEUMO	NIA	, ACUTE INTER	STITIAL		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque					
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	nce of):				
	be executed sicien and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
Ö,	e exer		resulting in death) Last	Due to (or as a conseque	nce of):				
98760	physic physic the b	Medical	d.					-	
Box	death certificate be executed e attending physicien and id for use as the burial-transi		IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnanc				23d. Date of de	ivery
Ö.	death	Physician/	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of dea 9 ☐ Unknown		Ectopic pregnancy Other (specify)		Month	Day Year
д О	The law requires that the de ste has been signed by the a page 2 should be detached t	Phy	9 ☐ Unknown Part II. Other significant conditions cont		ng in the un	darhina anuan avuan in Bart I	22a Did tob	pacco use contribute to	the enume of death?
ds,	signed by det		ACUTE RENY		-	denying cause given in Part i.		es 2 No 3 P	
Ö	w require been si should b	Completed by					24a. Was a	n 24b Were at	stoney findings available
Ř	: The law cete has	ошо					autops perform	ned? death?	utopsy findings available completion of cause of 2 No
Vital Records,		BeC	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only on		2 140
	Physic this ce at dire	မှု	1 ☐ Yes 2 THO					ence 6 Other (Spe	cify)
Division of	ding P. h. After t	tlon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
<u> </u>	r Attender death	flcat	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom	e, farm, stre		28f. Location (St.	reet and Number or R	ıral Route Number,
ă	0 # D :=	Certification:	4 Homicide	building, etc. (Specify)			City or Town		
	Hospitel 24 hours Funerel letely filled	edical	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examine one)	cian: To the best of my knowledge: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the ca red at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			29c. License number	1	9d. Date signed (Mont	
			> widt	MD		RES-000	> 1	WLY 21.	2006
			30. Name and address of person who con Robin Veidt 60	npleted cause of death (Item 2	3a) (Type, I	RES-000 treet Baltin		v4	171707
#P	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	·70 >	THECT PAITIN	nure	rany ylane	· CICOT
	Registr		AUG 0 4 21	32. Registrar's Signatur	Ro .	2-			
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician July 30, 2006 Bernardine Docherty 4:30 pm M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Heart Heritage Estate Street Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 89 Director 101-07-9190 22, 1916 New York Aug Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 7 is marked other than "natural", or items 23a or 28a-f shov treumatic event. the Medical Exominar must be notified at 1 Yes 2 No Directo MD Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 125 Bower Lane 21050 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Caucasian þ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry New York Elementary/Secondary (0-12) if Health and Mental Hygiene. College (1-4or 5+) 12th grade Clerk Liquor Authority 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Teofil Szmytkowski Francis Banas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Baylis Lane, Bedford, New York John P. Docherty Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 2, 2006 Brooklyn, New York Cypress Hills Cem. * 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6415 Belair Road, Baltimore, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) onsestine Henry **Physician** years /Medical Examiner Menny Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? detached for Day 4 Pregnant at time of death 5 Other (specify) P.0. Yes 25 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe 1 Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Assesped Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Inher (Specify) Certification: To CAM 28a. Date of Injury (Month, Day Year) 27. Manner of Peath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide ō Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 170 29c. License number 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) 70 July 31, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. MacpHail RD BelANND LARED SPANES 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 0 4 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrat Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical Name (If not institution, give street and number) 46, City, Town, or Location of Death Examiner 101 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 06-Director Usual Residence of Decedent tiled within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show the Medical Examiner must be notified at NIA Baltimore 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1526 Street Apt Letreat 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. I XXYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black δ Specify Specify: 3 Widowed 4 Divorced "naturel", Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1,4or 5+) mentary/Secondary (0-12) 10th grade es idential Caretaker permit. Pages 1 and 2 should be tiled v Department of Health and Mental Hygier Importent: if Item 27 is marked other th eny Injury or other traumatic event, that once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Engene Folwards, Sr. HIZabeth 19a. Informant's Name Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pearl H. Edwards/ Avenue 1609 Graves High Point 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Garnson n Hore C 22. Name and Address of Facility Pra Ser ANA DASSLON Have Street 08.07.06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart shirter. List only one cause on each line. Baltimore MD Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCAPSIM INFARCTION /Medical Due to (or as a consequence of) Examiner ATTE TO SLEPOTIC APAIOUAS CULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit l or Attending Physician: The law requires that the death certilicate be executed HYBERTENSION Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 ☐ Fetal death 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 4 Unknown 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 21 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be (25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PER/Outpatient 3 □ DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Atter 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely tilled in by the fu 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only

State Registrar

31. Date filed (Month, Day, Year) 0 4 2006

WASHINGTON

one)

30. Name and a

009

29b. Signature and title of certifi

Rows Bon 32 Registrar's Signature

dress of person who completed cause of death (Item 23a) (Type, Print)

91751 mom

29d. Date signed (Month, Day, Year)

29c. License number

30408

DHMH 17 Rev 1/2001

	1	For State Registrar 1. Decedent's Name (First, Middle,		aryland / Do	Certificat				Rag.	71	106	2448
ician	n.	William	•	Edward		(Gee	2. Date o Month		Day	Year	3. Time of Death
dica nine		4a. Facility Name (If not institution,			4b. City,		Location of I	08 Death	-		2006 ty of Death	4:45a.
		Manor Care N					nore				,	
l r		217-12-6855	6. Sex 7. Ag 1 ★ 2 F	ge (In yrs. last birth 88 Yr	Months		If Under 24 Hours	Hrs. 8. Date of (Month)	Birth Day, Yea	ar) 18	9. Birthi Coul	otace (State or Foreigntry) VA
	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limit
101	0	MD NA		Baltin	ore							Y☐Yes 2☐N
Director	ě	10e. Street and Number			10f. Zip	Code			10g.	Citizen of	What Cou	ntry?
		1669 Falls Ro					L209			U	.S.A	•
Funarai	E L	11. Marital Status	12. Was Decedent Armed Forces?	?	 Was Deceded If Yes, specified 	dent of Hi cify Cuba	ispanic Origin n, Mexican, F	? (Specify Yes or Puerto Rican, etc.	No-		ace - Amendack, White,	
2	2	1 ☐ Never Married 2 ☐ Marrie 3X Widowed 4 ☐ Divorced	lf Yes 2 ☐ If Yes, Give Year or Dates:	No	1 🗆 Yes	2[X No	Specify:			Speci	ity: B.	lack
Completed		15. Decedent's	s Education	16a. D	ecedent's Usua	al Occupa	ation	· · · · · · · · · · · · · · · · · · ·	16b.	Kind of 8	Business/In	dustry
nnie		(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	Give kind of wo fe. DO NOT us	se retired	during most of	working				
		7th grade 17. Father's Name (First, Middle, L	na	Co	nstru	ctic						ion Co.
Be	ă							Name (First, Mic	die, Maid	en Suma	ime)	
L	5 7	Villiam Sidne 19a. Informant's Name/Relationsh		19b A	failing Address	(Street a		r Epps or Rural Route Nu	mher Cit	v or Town	State Zir	Code
ì	l,	Elizabeth Jac						ad, Ba				21207
		20a. Method of Disposition		20b. Place of D		ne of	1	Date	-		- City or To	
		ty□ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp.	3 □Removal from State ecify)	Garris	,		1	/8/06	Ow	ina	s Mi	lls, Md
•		21. Signature of Fineral Service L	4	1	22. Name an	d Addres	s of Facility		- Ow	9	J 111.	LIB, IId
-	1	23a. Part1. Enter the disease, or o	nonah	an	March 4300	Waba	ash At	re, Bal	timo	re,	Md	21215
icai Examiner		shock, of heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions from the failure of the failu	a. Due to (or as b. Due to (or as c. Due to (or as	a consequence of) My Cyfhe	mie,		Chine					Inierval Batween Onset and Death
			d	7.5 FE-MINE	CS							
Physician/Med	1 yaıcıdı vivi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pr 5 ☐ Other (sp						ate of delive onth	ery Day Year
by P	2	Part II. Other significant condition	s contributing to death b	ut not resulting in th	ne underlying ca	ause give	n in Part I.	23e. D	d tobacco	use con	tribute to th	ne cause of death?
ed		Degenso	the Jo	mt	DIFER	e		_ 1	⊒ Yes	2□No	3 Prob	ably 4 Unknow
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Be	0	25. Was case referred to medical examiner?					26. Place of	Death Check on		10	1 1 1 1 1 1 1 1	2010
ျှ	2	1 Yes 2 No	Hospital: 1 Inpatie		atient 3 DO	Othe	r: 4 Wursir	ng Home 5 □ R	esidence	6 □Otl	her (Specif)	()
1 ;;	5	27. Manner of Death 1 ☐ Natural 5 ☐ Pending		y Year) 28b. Tim y Year) Inju		8c. Injury Work	at ?	28d. Descri				
5	ğ	2 Accident investiga 3 Suicide 6 Could no	ot be Goo Bloco of Inc	un. At home form	M		′es 2□No	204	/Ct			
cation	2	4 Homicide determin	building, et	ury - At home, farm c. (Specify)	, street, factory	, опісе		City or	Town, Sta	and Numi ite)	ber or Hura	l Route Number,
ertification												
dical Certification:		29a. Certifier 1 TCertifying	Physician: To the best xaminer: On the basis of and manner sta	f examination and/o	eath occurred a rinvestigation,	at the tim in my op	e, date and p inion, death o	lace, and due to to occurred at the tin	ne cause(e, date a	s) and m nd place,	anner as st and due to	ated. the cause(s)
Medical Certification	בחוכם	29a. Certifier 1 Certifying	xaminer: On the basis of	f examination and/o	or investigation,	at the tim in my op . License	inion, death o	lace, and due to to occurred at the tin	e, date a	nd place,	anner as st and due to ed (Month, I	the cause(s)
edicai	בחוכם	29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical E	xaminer: On the basis of	f examination and/o	er investigation,	in my op License	inion, death o	occurred at the tin	e, date a	nd place, late signe	and due to	the cause(s)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 22 per fh e858 8-4-06 vt. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician Jorothi 3:04PM Graves 2006 August /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Randallstown Hospita Raltimore Northwest If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 □ M 2 ■ F Months Yrs. 216-20-5057A 12/31/1925 MDDirector Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County if item 27 is marked other then "naturel", or items 23s or 28s-f ehow or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Baltimore MD winas 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Apt. 21117 Enchanted 11:41 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after a nand Mental Hygiene. is marked other then "naturel", or iter 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 SNo Specify: Specify: þ Black 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LIERK NA permit. Pages 1 end 2 should be file Department of Health and Mental Hy, Importent: If flem 27 is marked othe eny injury or other traumatic event, 2008. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Annie Kichards ၉ James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3228 Dorithan Rd, Baltimore, MD 21215 Delores Bishop (cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 22. Name and Actoress of Facility Funeral SYC Dulaney 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 21. Signature of Funeral Service Licensee Vauchn (5151 Balto North Pike, Baltimore, MD 21229 Greene 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Anoxic Drain mur /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): cardiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit Myocardie tarc Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Pase oronar IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown breast cancer 24a. Was an autopsy performed!
1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificete has funeral director, page 2: Systemic inflammatory response syndrome Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ۵ 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No М death. 124 hours after death.

• Funerel Director: Aletely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the H.
within 24 l.
To the Fun.
Shipletely fit 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28462 Socton MD August 2 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Randallstown, Maryland Northwest Hospital Boston 32. Registrar's Signature

State

Registrar

31. Date filed (Month, Day, Year)

AUG

0 4 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MEND 1TH#/19a, perfff, G558, 8/8/06, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Lucy July 19, M. Garner 2006 10:57 a ^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4025 Frederick Avenue Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2**X**☐ F 93 Yrs. 239-40-5830 04/28/1913 North Carolina Usual Residence of Decedent 10b Counts 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4025 Frederick Avenue 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify **Black** Specify: 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic 7th Private Homes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jim Miller Mary 19a. Informant's Name (Retailorship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn McNell (daughter) 605 N. Longwood St., Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olive Cen 07/26/2006 Mt. Olive, N.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bernadine V. Scruggs per DVR Calvin B. Scruggs Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Myocardial Infarction Due to (or as a consequence of): Coronary Artery Disease Due to (or as a consequence of): Congestive Heart Failure Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Tyes

Physician /Medical Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland pages 1 and 2 should be filed within 72 hours after death with the Maryland pageriment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic averages.

use as the burial-transit Completed by Physician/Medical Be ٩ within 24 hours effer death.
To the Funeral Director: Affer thi
completely filled in by the funeral Certification:

To the Hospital or Attending Physician: The law requires that the death certificate be executed

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Division of Vital Records, P.O. Box 68760,

f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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Medical

State Registrar

cause of death (Item 23a) (Type, Print) Sosanya

05 am

31. Date filed (Month, Day, Year) AUG 0 4 2006

M.D., 2600 Liberty Heights Ave., Baltimore, MD 21215 32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

1 #19a&b -20a c&22 Per FH C858 8/16/06 IH
#24a, 255, 265, 27 Margan per Penaytroen sor Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 0 6 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 20 3:15 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death Examiner 4b. City, Town, or Location of Death BALTIMORE 130N If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year)

Jan 3, 1932 5. Social Security Number Birthplace (State or Foreign Country)
 unk 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 21XF 74 578-40-1877 Yrs Director Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 28a-1 show 10d. Inside City Limits the Medical Examiner must be notified a MD Director Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 22 S. Athol Avenue 21229 USA Items 23a death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after unk 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: white 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk unk or other traumatic event, 17. Father's Name (First, Middle, Last) Be unk 18. Mother's Name (First, Middle, Maiden Sumame) unk Pages 1 and 2 should be Tent of Health and Mental 2 Alice BellamyGuardian 190 Mailing Cid 186 Except a STY were or AGH Bould O Onto BAIVO O MID (418, Zip Code) Department of Health a Important: If Item 27 le any injury or other trai Bon Secours Hospital 2000 W. Baltimore Street Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state 8/16/2006 Catonsville,MD Metro Crematory Wylie Funeral Home pe mit. 21. Secuture 1 Juneral Service Licensee Ronal d S. Wade State Milaton 21201 21217 enn Baltimore, MD 638 N.Gilmore Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** VE CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sicien and burial-transit The law requires that the death certificate be executed QUETIVE PULMONARY Box 68760 Physician/Medical the phy IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ٥ Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☑ No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 99 Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? page Vital this certificete 1 ☐ Yes Attending Physician: director 25. Was case referred to medical Be 26. Place of Death | Check only one Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ို 1 ☐ Yes 2XX to XInpatient 2 ER/Outpatient 3 DOA o 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred After 1XX atural 5 Pending investigation ivision s after dea. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled i **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D0030355 J4LY 20,2006 BON SECOURS HOSP, TAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2006 Registrar Û 12 16800

06-05495 Ter

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Terrel Griffin	St For State	ate of Marylaı	nd / Departn <i>Certifi</i> c	nent of <i>cate of</i>	Health a Death	nd Men	tal Hyg		leg. No.	201	15 21.1.8
	gistrar Decedent's Name (First, Midd	le,Last)					2	Date of Dea	ath	V	3. Time of Death
Medical Examiner	TERREL A. GRIFFII	N						Month July 28, 2	006	Year	0534 hrs
4	a. Facility Name (if not institution Sinai Hospital	on, give street and nun	nber)	4	b. City, Town, Baltimore	or Location				. County of Deati	
Funeral 5	. Social Security Number	6. Sex	7. Age (In yrs. last b	oirthday)	If Under 1 Y					DD/YYYY) 9. Bii Forei	rthplace (State or
Director	216-19-4092	1 M 2 F	18	Yrs.	Months D	ys Hour	s Min.	11/08/	1987		ountry) MD
	sual Residence of Decedent		10c. City, Tov	un or Locati	00						10d. Inside City Limits
æ	0a. State 10b. County 1ARYLAND	ĮA		TIMORE	OII						1 Yes 2 No
Maryland 28a-f show d at once	Oe. Street and Number	W.	120		10f. Zip Code	-			10g. Citi:	zen of What Cou	
th the Maryland 23a or 28a-f sho notified at once al Director	2616 OSWEGO AVENUE	,			21215					USA	
ith the satisfactor of the satis	1. Mantal Status		edent Ever in U.S.		s Decedent of				0-	14. Race - Ame	rican Indian, Black,
or items 23		Married Armed Fo	rces?		es, specify Cub			Rican, etc.)	į	White, etc.	T ACTZ
s after d		vorced If Yes, Give Year or Dates:			Yes 2 X					орссиу.	LACK
Annatura Samui	15. Decedent's Education (Spe			a. Deceden during m	t's Usual Occu ost of working	oation (Give ife. DO NO	Fuse retire	ork done ed)	16b. r	Kind of Business	Andustry
5-0036 ed within 72 hour lygiene. the Medical Exau Completed	Elementary/Secondary (0-12)) College (1 NA	-4 Or 5+)	NEVER	WORKED					NA	
d with d with the true to the	7. Father's Name (First, Middle					18.Mothe	er's Name	(First, Middle	, Maiden		
21215-0036 uld be filed within 7 Mental Hygiens marked other than c event, the Medica for December 1 Medica fo	ALFRED JL GRIFFIN						EY JON				
21 Double 1	9a. Informant's Name/Relation									ity or Town, Stat	
MD and 2 sho alth and 2 sho m 27 is	DENISE HOLLEY 20a. Method of Disposition	COUSIN	20b. Plac		ROYSTON A sition (Name of		BALT	Date		AND 21214 Location - City of	
W		on 3 Removal fr	om State crer	matory or ot	her place)				1		
timent trant:	4 Donation 5 Other S 21. Signature of Funeral Service	Specify:	TRIN	ITY CE	METERY Name and Add	ess of Facil	AUG 5	, 2006	<u> BA</u>	LTIMORE,	MARYLAND
Balt permit. Departi Importi Injury	21. Signature of Furieral Service	t Licensec								RYLAND 21	217
Physician	23a. Part I. Enter the disease, of	or complications that c	aused the death. Do	o not enter t	he mode of dy	ng, such as	cardiac or	respiratory a	rrest, sh	ock, or heart	Approximate Interval Between Onset and
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	or condition resulting in death)		consequence of):								
<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):								
ii iii	cause. Enter Underlying Caus (Disease or injury that initiated	e c									
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ox 6876 ath certificate attending phy or use as the 's sician/M	23b. Was decedent pregnant in past 12 months?		oirth nant at time of death		etal death ther (Specify)	3Ecto	pic pregna	ncy		Month	Day Year
Records, P.O. Box 68760 The law requires that the death certificate cate has been signed by the attending phypage 2 should be detached for use as the Completed by Physician/Me		Jnknown 9 Unkn									
O. Boat the de day the stacked of Phy.	Part II. Other significant cond	ditions contributing t	o death but not resu	ulting in the	underlying cau	se given in	Part I.				to the cause of death?
Division of Vital Records, P.O. rate death. The law requires that the safter death. The law requires that the safter death. The this certificate has been signed by all Directors. After this certificate has been signed by the fineral director, page 2 should be detacted in by the fineral director, page 2 should be death efficient to Be Completed by P								24a. W			autopsy findings available
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Sion Atten	2 Accident In	vestigation 28e. Pla	ce of Injury - At hom	ne, farm, str	eet, factory, off	ce building	etc.			and Number or	Rural Route Number, City
Division of Hospital or Attending, 24 hours after death, Funeral Director: Afte tely filled in by the fune		ould not be etermined (Specify	Local Street					2600 Blo	n, State) ck Loyd	ola Southwa	y, Baltimore, MD
	29a. Certifier	Physician: To the be xaminer: On the basis	est of my knowledge of examination and	e, death occ d/or investig	urred at the tim ation, in my op	e, date and nion, death	place, and occurred a	d due to the cat the time, d	ause(s) a ate and p	and manner as s place, and due to	tarted. the cause(s)
To the Ho within 24 To the Fu complete!	29b. Signature and title of cert	and manner	stated.			cense numb					Month, Day, Year)
	1/1	11. 11	0016	les	C	.C.M.E.			Jυ	ly 28, 2006	
\	30. Name and address of pers	son who completed car	use of death (Item 2	23a)							
	Pamela Southall, M	D Assistant M	edical Examine	er 111	Penn Stree	t, Baltim	ore, MD	21201			
State Registrar	31. Date filed (Month, Day, Yea	^{ar)} 2006	Registrar's Signature		de					·	

DHMH 17 Rev 1/2001

Registrar

		ļ	1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of H			jiene	16	24488
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	pkins				AMonth	th Day	Year	3. Time of Death 748 A M
	Examin Funeral Director		4a. Feqility Name (If not institution, give : North w.e. St 5. Social Security Number 6. Sex	HOSPI 7. Age	+a (In yrs. last birthday 30 Yrs.	Rand	Location of Deat A S If Under 24 Hrs Hours Min.	own	Bal (Year)	tin	ace (State or Foreign
	ס	Director	Usual Residence of Decedent 10a. State 10b. County Md. NA 10e. Street and Number		10c. City, Town or L	ocation Ltimore			0g. Citizen of W		Va. Od. Inside City Limits 1 ▼Yes 2 □ No
2-0020	hours after tural', or ite	by Funeral	2229 Homewood Ave 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade)	12. Was Decedent E Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	o 16a. Dece	Was Decedent of H If Yes, specify Cuba □ Yes ※□ No adent's Usual Occup- s kind of work done of	ispanic Origin? (S In, Mexican, Puerl Specify: ation		14. Race	DIG	ack
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saitimore,	Pa ant ury		20a. Method of Disposition	emoval from State	20b. Place of Disp cemetery, cre Woodlav	matory or other plac	8-9-		20c. Location - (
Dall	permit. Pa Departmen Importent: any injury		21. Signature of Funeral Service Licensus 23a. Part 1. Enter the disease, or compli	Cork		2. Name and Address March F. H.	. East	1101 E.	imore, I North	Ave.	21202
	Physician /Medical Examiner physician and physician and the private the private the private the private the private the private the private the private the private the private the private the physician and physician are private the pr	il Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a	consequence of):	(T)	i mol		33.		Interval Between Onset and Death
O. DOX 00/00	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes '2 No 9 Unknown	d. 3c. If yes, outcome o 1⊡Live birth 2 4⊡ Pregnant at ti 9⊡ Unknown	2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mon	of deliver	y Day Year
ecords, r	equires that en signed t	by	Part II. Other significant conditions cor	itributing to death but	t not resulting in the	underlying cause give	en in Part I.			bute to the	cause of death?
		Completed						24a. Was a autops perform 1 Yes 2	neg? (ae	ere autopo ior to com eath? Yes 2	sy findings available pletion of cause of
OI VIIAI	Physician: this certific al director,	To Be	1 105 212 110	lospital: 1 Inpatien			ar: 4 ☐ Nursing H	th (Check only on	nce 6 Other		
UNISION	To the Hospitel or Attending Physician: within 24 hours after deals as a feet deals To the Funerel Director: After this certific completely filled in by the funeral director.	Certification;	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Description 27. Manner of Death 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	M 1□'	y at (? Yes 2 □ No	28d. Describe ho			Route Number
2	ospitel or / hours after inerel Dire y filled in b		29a. Certifier 12 Certifying Phys	building, etc.	(Specify) f my knowledge, dea	th occurred at the tim	ne, date and place	City or Town	use(s) and man	ner as sta	ted.
	To the He within 24 To the Fu	Medical	(Check only 2 Medical Examination) 29b. Signature and title of certifier	ner: On the basis of e and manner state	ed.	29c. License			ate and place, ar		
	12		30. Name and address of person who co	aj who	ath (Item 23a) (Type	(2 °			Augus	5+ 2	2006
	Sta	_	Christine Kaju 31. Date filed (Month, Day, Year)	b 1 5401 32. Registrar	old Cou	ert Koa	d'Kan	dallst	ownl	Mar	yland
	Registr	ar	AUG U 4 Z	106	5 St. 6	DANE					

06-05589 Irvin J. Harris

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INK UNK		I- For State	State	of Maryland	•	rtment of tificate of		ia Menta		Reg. No.	200	01.1.0
Physicia	n/	Registrar 1. Decedent's Name	(First, Middle,La	st)					2. Date of De	eath Day	Year	3. Time of Death
Medical Examir		Irvi		J.			ris b. City, Town,	ar Logotion of	July 30,	2006	ounty of Deat	2252 hrs
		3000 Belair F	· -	ve street and number)		1	Baltimore	DI EUCAHOIT OI	Death	170.00	NA	
Funeral		5. Social Security Nu	ımber 6. S	Sex 7. Ag	e (In yrs. la	ast birthday)	If Under 1 Ye			Birth (MM/DD	YYYY) 9. Bi Forei	rthplace (State or
Director	l	215-43-4810	15	X M 2 F	11	Yrs.	Months Da	ays Hours	Min. 12-00	3-1994		puntry) Md.
any	F	Usual Residence of 10a. State 1	Decedent 0b. County		10c. City,	Town or Location	on				_	10d. Inside City Limits
5 .		Md.	7	A	E	Baltimore						1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Num			L		10f. Zip Code			10g Citizen	of What Cou	intry?
with the Maryland \$ 23a or 28a-f show tootified at once.		3105 Lawn	view Ave.				21.21			USA		
tems 2	Funeral	11. Marital Status 1 X Never Marrie	d 2 Marrie	d Armed Forces	·		Decedent of F es, specify Cub	lispanic Origir an, Mexican, I	n? (Specify Yes or I Puerto Rican, etc.)	No- 14.	Race - Ame: White, etc.	rican Indian, Black,
fter de		3 Widowed		1 Yes 2 If Yes, Give Year or Dates:	X No	1	Yes 2 X	lo specify:		Spe	ecify: B	lack
natura	q pe			only highest grade cor			's Usual Occup est of working li		nd of work done ise retired)	16b. Kind	of Business	/Industry
36 in 72 l han ",	plet	Elementary/Secon	ndary (0-12)	College (1-4 or	5+)	Studer	nt-			, N	I A	
5-0036 led within 72 hours after dygiene other than "natural", the Medical Examiner.	Completed by	17. Father's Name (F	irst, Middle, Las	it)		Dear	ic .	18 Mother's	Name (First, Middle			
21215-0036 suld be filed within 7 Mental Hygiene marked other than c event, the Medica	a	Aaron		dney	Har	ris		Shand		Reid-Ve		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ten of Heath and Mental Hygiene unt: If item 27 is marked other than "natural", or items 23a or 28a-f short other traumatic event, the Medical Examiner must be notified at once	၉	19a. Informant's Nar							oer or Rural Route N altimore, Mc			e, Zip Code)
e, M 1 and 2 Health item 2		Shanda Har 20a. Method of Disp	osition	<u>Mother</u>		Place of Disposi crematory or oth		cemetery,	Date	20c. Loc	ation - City o	r Town, State
MOF Pages ent of mut: If		Burial 2 Donation 5		Removal from St		ting Mem.			8-7-06	Rand	bllstow	n, Md.
Baltimore, MD 21215 permit Pages I and 2 should be file Department of Health and Mental H Important: If item 27 is marked or injury or other traumartic event, th	1	21. Signature of Fur			(1)		ame and Addre				Md. 2	1202
Physician	-	2 1. Part I. Enter the	disease, or con	nplications that caused	the death.		erch F¶H¶ ne mode of dylr		1101 E. N			Approximate Interval
/Med cal		failure. List only In mediate Cause (F	y one cause on e	each line. a Multiple Stab a								Between Onset and Death
Examiner	1	r condition resultin		Due to (or as a cons	equence o	f):						
	E.	Sequentially list con if any, leading to im-	mediate	Due to (or as a cons	equence o	f):						
là/	Examiner	(Disease or injury th	at initiated	Due to (or as a cons	equence o	f)·						
	Ë	events resulting in o	•	d								
O, e be executed ysician and burial - transit	Medical	UNPENDED		AMENDED								
(e = e	n/Me	IF FEMALE: 23b. Was decedent p		23c. If yes, outco	me of preg		tal death	B Ectopic	pregnancy		ate of deliver	Day Year
ox 687 cath certific attending	sician/	past 12 months		4 Pregnant a	t time of de		ner (Specify)			291		
Division of Vital Records, P.O. Box 687 rate of Attending Physician: The law requires that the death certifical and for death. **Attending Physician*** **The law rector: After this certificate has been signed by the attending red in by the funeral director, page 2 should be detached for use as the contract of the state of the contract of the state of t	Phys			9 Unknown s contributing to dea	th but not r	esulting in the u	nderlying caus	e given in Par	t I. 23e. Dio	tobacco use	contribute to	the cause of death?
P.C es that igned l	Ď						, -			′es 2 ✓ N	lo 3 Pro	obably 4 Unknown
rds, requir	lete								24a Wa	as an copsy		utopsy findings available completion of cause of
Reco	Completed								pe 1 ✓ Ye	formed? s 2 No	death?	′es 2 No
tal Finan: Trian	BeC	25. Was case referr examiner?	ed to medical	Hospital:		1		Other	Check only one)			
f Vil Physic er this rral dir	ဥ		2 No	28a. Date of In	ent 2	ER/Outpatient 28b. Time of I		njury at Work?	Nursing Home 5	Residence	e 6 🗹 Othe	er: Scene
On O	tion	1 Natural	5 Pending	FOUND: Day	Year)	FOUND: 2252 hrs	1	Yes 2	Deceased	stabbed		
ivisior for Attend after death Director:	ifica	2 Accident 3 Suicide	Investiga 6 Could no	28e Place of I	njury - At h	ome, farm, stree	et, factory, offic	e building, etc		n (Street and	Number or R	ural Route Number, City
Di spital o nours a neral l	Certification:	4 V Homicide	determin	(opeciny) VV					3000 Bela	ir Road, E	Baltimore,	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate burns after death To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 (Check only one) 2	Certifying Phys Medical Examin	ician: To the best of r ner:On the basis of ex	ny knowled amination a	lge, death occur and/or investigat	red at the time, ion, in my opin	date and plac ion, death occ	ce, and due to the ca curred at the time, da	ause(s) and nate and place.	nanner as sta , and due to t	rted. he cause(s)
To T To T	Medical	29b. Signature and	1/1	and mariner stated	1			nse number				onth, Day, Year)
		XIV	INI				0.0	C.M.E.		July 3	1, 2006	
3				o completed cause of			n Strock D	altimore N	MD 21201			- M
		Susan Hoga		sistant Medical E			n Street, B	aiumore, IV	110 Z 1ZU I			
S Regis	tate	31. Date filed (Mon	UG 0 4 2	2006 32. Geo glisti	الم المعبالية الم	S. Go	20/2					

06-05514 OI

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llie Mae Harris		State of Maryland / Department of Health and Mental Hy	giene		
		1- For State Certificate of Death Registrar		g. No 201	15 2449
Physicia ledical Examin	n/ er	1. Decodent's Name (First, Middle, Last) 1. Decodent's Name (First, Middle, Last) 1. Decodent's Name (First, Middle, Last)	2. Date of Death Month July 28, 20	Day Year	3. Time of Death 1438 hrs
A The Control of the		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1100 Bolton Street Apartment 1413 Baltimore City		4c. County of Dea	th
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	8. Date of Birth	(MM/DD/YYYY) 9. B	rthplace (State or
Director		217-36-3923 1 M 2 F G3 Yrs. Months Days Hours Min.	9-2-		ountry) MD
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits
·land -f show once.	힏	MD Baltimore			1 Yes 2 No
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is market other than "natural", or items 23a or 28a-f showmatic event, the Medical Examiner must be notified at once.	E l	100 Bolton Street 21201		g. Citizen of What Co	untry?
ems 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 15. Was Decedent of Hispanic Origin? (Sp. 16. Was Decedent of Hispa		14. Race - Ame White, etc.	rican Indian, Black,
after de	by Fu	3 Widowed 4 Divorced of Pates: 1 Yes 2 No 1 Yes 2 No specify:		Specify:	lack
hours "uatur	اير	15. Decedent's Education (Specify only highest grade completed) Elemenjary/Secondary (0-12) College (1-4 or 5+)		16b. Kind of Business	/Industry
21215-0036 hould be filed within 72 nd Mental Hygiene. is marked other than atic event, the Medical	Complete	1240 Expiditor		Northro	Gruman
e, MD 21215-003 1 and 2 should be filed within Health and Mental Hygiene "item 27's marked other of r tranmatic event, the Mec	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name A (A >)	(First, Middle, M	laiden Surname)	a.)
212 rould be d Ment d Ment is mark		19a. Informant's Name/Relationship (Tybe. Print.) (5/5/er) 19b. Mailing Address (Street and Number or R	ura Route Numb	ber, City or Town, Stat	e. Zip Coo2 0623
- P# = # -	1	Jan ico Hartwell - Nuller 9609 Spinnaler 20a. Method of Disposition (Name of cemetery,	Date Date	20c. Location - City of	r Zown, State
Baltimore, pernit Pages I ar Department of He Important: If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	11100	Rolling	ON MI)
Baltimore perinit Pages I Department of F Important: If injury or other	Ť	21 Signature of Funeral Service Licensee	ices	F.A.	a qui
Physician	-	23a. Int Enter the disease, in complications that caused the death. Do not enter the mode of Tyring, such as cardiac or	respiratory arre	PIKE BA	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Hypertensive Atherosclerotic Cardiovascular Disease			Between Onset and Death
, and the second		or condition resulting in death) Due to (or as a consequence of):			
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
oe executed ician and irial - transit	dical	UNPENDED AMENDED			
	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ncy	23d Date of delive	ry Day Year
Box 68760 • death certificate I the attending physelor use as the buse	sician/Me	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✓ No 9 Unknown		1	
O. B. that the de led by the detached f	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	bacco use contribute t	o the cause of death?
S, P.O. uires that th n signed by id be detack	ed by	Diabetes Mellitus			obably 4 Unknown
cords,	Completed		24a. Was a autops perforr	sy prior to	utopsy findings available completion of cause of
tal Rec	e Co	25. Was case referred to medical 26.Place of Death (Check of D		2 ✓ No 1	res 2 No
Vital visician: this certif	B	examiner?		Residence 6 🗸 Oth	er: Scene
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate optimin 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	on: T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe h	ow injury occurred	
livisior I or Attend after death Director: d in by the	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.			tural Route Number, City
Divi Hospital or 24 hours afte Funeral Dir tely filled in	Certi	4 Homicide determined (Specify)	or Town, St	ate)	
To the Hospital within 24 hours To the Funeral Completely filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
P 1 P 3	Me	29b. Signature and title of certifier 29c. License number		29d Date signed (M	onth, Day, Year)
		hoyante Shelfall O.C.M.E.		July 29, 2006	
5		 Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2 	21201		
St Regist		31. Date filed (Month, Day, Year) ALIC 0 4 2006			

			1 - For State Registrar	State of I	Marylan			nt of H te of L				Reg. No.	006	244	-
	Physici /Medic		1. Decedent's Name (First, Middle, I Isaac Kieth Hari	•							2. Date of De	eath OI	2්0ී්රී6	3. Time of 6:50	Death a M
	Examir		4a. Facility Name (If not institution, g Montgomery Gener		•		4b. City O1n	, Town, or Ley	Location	of Death			unty of Death tgomery	7	
	Funeral Director		310-12-39/3	Sex 7. 1 M M 2 ☐ F	Age (In yrs.	(ast birthday) Yrs.	If Unde Months	Days	If Under Hours	Min.	8. Date of Bi	rth ay, Year) 1917	Cour	lace (State or htry) ahoma	Foreign
	Maryland f ehow led at	tor	Usual Residence of Decedent 10a. State 10b. County MD Montgor	nery		y, Town or Lo							1	0d. Inside Cit	•
	h with the	al Director	10e. Street and Number 15310 Beaverbroo	ok Ct.	10f. Zip Code 20906					10g. Citizen of What Country?					
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or Itema 23a or 28a-f ehow shi righty or other traumatic event, Ira Madical Eventina must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 ■ Yes 2[1 Myes, Give Year or Dates: unknown Ication to completed) 16a. Deced (Give (1.40r 5±)			Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: dent's Usual Occupation kind of work done during most of working DO NOT use retired) istical & Research Cler				No- 14. Race - American Indian, Black, White, etc. Specify: White			
	within 72 ho ene. then "natu	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	rade completed)								16b. Kind of Busine		ss/Industry Government	
land 2	uld be filed Mental Hygi Irked other Itic event, I	To Be Co	17. Father's Name (First, Middle, La Roger Nelson Han								(First, Middle		mame)		
	and 2 sho salth and I n 27 is mu ar traume		19a. Informant's Name/Relationship Keith Miller Hari	(Type, Print) Cison/son							ilRoute Numb		own, State, Zip 51	Code)	
Baltimore,	Pages 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spe			lace of Dispo emetery, crer Lence (matory or	me of other plac	e)	8-3-	2006	20c. Locat	ion - City or To a, CO	own, State	
Balt	permit. Departr Importe eny inju		21. Signature of Funeral Service Lic	Z moi35	Š			nd Addres		*		_	ring,MI 3 Gist		
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	ty one cause on each Conge a. Due to (or	n line.	Heart uence of):			g, such as	cardiac o	r respiratory a	irrest,	3	Approximate Interval Betw Onset and D Years	veen leath
,820,	ficate be executed physician and is the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or and d.	as a consequ	s a consequence of):									
.O. Box 6	the death certi y the attending iched for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknown	2 Fetal at time of de	death 3	Ectopic p Other (s					23d	. Date of delive Month	,	ear
rds, P.	law requires that as been signed b 2 should be deta	by	Part II. Other significant conditions	contributing to death	n but not resi	ulting in the u	nderlying	cause give	en in Part	l. 		tobacco use Yes 2 N	contribute to the	ie cause of de ably 4 ∏Ui	
Division of Vital Records,	The ate h page	Completed				-					24a. Was auto perfo 1 Tyes		death?	psy findings a npletion of ca 2 No	vailable use of
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Kinpa		FD/0		Othe			Check only				
ion of	Jing After fune	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of II (Month, I		ER/Outpatien 28b. Time of Injury		28c. Injury Work	4 14	2	ne 5 ☐ Resi 28d. Describe		Other (Specify	/)	
Divis	tal or Attenders after death al Director: ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of	28e. Place of Injury - At home, farm, street, factory, office 28f. Lo						28f. Location (City or To		umber or Rura	l Route Numb	Θ <i>f</i> ,
	To the Hospital within 24 hours a To the Funeral completely filled	edicai	one) 2 Medical Ex	Physician: To the be aminer: On the basis and manner	of examinal	wledge, death tion and/or in	vestigation	n, in my op	oinion, dea	nd place, a ath occurre	and due to the ed at the time,	date and pla	ce, and due to	the cause(s)	
)	with To mos	Σ	29b. Signature and title of certifier	Cody W	uf		29	C. License	number	-8		11	gned (Month,		
	10%		30. Name and address of person wh Thomas E. Dooley		7		e. 01	ney,	MD 2	20830		100			ati Posti tudi ilikusiisida
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0	1 2006 32. Regi	strar's Signa	ture	A STATE OF THE STA								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** OSE HOUEHENS 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HOSPITAL BON SECOURS BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Y 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9/ Birthplace (State or Foreign **Funeral** 18-48-0363 1 □ M 2 X F 59 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be routiled at 1 Yes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Inomas 19a. Informant's Name/Relationship (Type, Print) (auc 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important; If Item 27 is m any injury or other traum once. 2 Balto.Md Varren 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 2006 3 Removal from State *4 ☐ Donation 5 ☐ Other (Specify) Cemetery Name and Address Hacility
Joseph
2222 W. North Ave Bolto Md. 21. Signature of Funeral Service Licensee 23a. Part1 Enter the disease, or complications that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirtly or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final **Physician** TICEMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ERTENSIVE CARDIOVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e o (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit DIABETES MELLITUS the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. RENAL DISEASE Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month 4□Pregnant at time of death 5 Other (specify) 9 12 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Planknown Completed this certificate has been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 1 No 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Tyes 2 🖳 ⊀0 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Hospital 29a. Certifier 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 80030355 31, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BON SECOURS <0 SITA 32 Registrar's Signature 31. Date liled (Month, Day, Year) State AUG 0 4 a com 2006 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [24493 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 0540 0 7006 FRED . HOWZELL /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CO BALTIMORE
If Under 1 Year | If Under 24 Hrs. AUGSBURG LUTHERAN HOME & VILLAGE Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2□F Months Days Hours Min. 85 Director SOUTH CAROLINA 251-40-6287 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location rthan "natural", or Items 23a or 28a-f show the Medical Expringer, just be notified at 1 ☐ Yes 2 ☑ No BALTIMORE MARYLAND BALTIMORE Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 U.S.A. 6811 CAMPFIELD ROAD death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (A)No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 ☐ No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) POTTS & CALLAHAN CONSTRUCTION 8th grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HENRY HOWZELL IDA MAE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Freddie Thomas/Son 312 Aiken Terrance, Abingdon, Maryland 21009 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08-02-06 * 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY BALTIMORE, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death inmediate Cause (Final disease or condition resulting in death) obstructive **Physician** HYDNIC Pavs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 1☐Live birth 3 Ectopic pregnancy 2 Fetal death Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate ! 1 Yes 2**5** No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 4€ Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 37573 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7ibell 5 Man 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 0 4 2006

				1 For State	ite of Maryland / De		lealth and M	ental Hygie	ne nns	21,494
		- F - 21	ig.	Registrar 1. Decedent's Name (First, Middle, Last)		crimeate of L	Jean	Reg. 2. Date of Death	No:- 0	3. Time of Death
4	25	Physic /Medi	cal	Charles Herrington 4a. Facility Name (If not institution, give street a	Ab City Town or	Location of Death	July 31, 2006		9:40 AM	
•		Exami	ner	Joseph Richey Hospi			4c. County of Death			
		Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year	ltimore If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birthi	place (State or Foreign
		Director		214-50-1910 Usual Residence of Decedent	□ F 57 Yrs.	Months Days	Hours Min.	(Month, Day, Ye Nov 14, 1	948 Cou	unk unk
		yland now		10a. State 10b. County	10c. City, Town or	Location				Od. Inside City Limits
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		ter de	Funerai	11. Marital Status 12. Wa Am 1 X Never Married 2 Married 1 ☐	s Decedent Ever in U.S. ned Forces?	 Was Decedent of Hill If Yes, specify Cuba 	ispanic Origin? (Spe n, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
	036	ours at	by	3 ☐ Widowed 4 ☐ Divorced Year]Yes 2 🔀 No es, Give ar or Dates:	1 ☐ Yes 2 🔀 No	Specify:		Specify: b	lack
	21215-0036	in 72 ho "natu edicel	Completed	15. Decedent's Education (Specify only highest grade comp	leted) (Giv	cedent's Usual Occupa ve kind of work done of DO NOT use retired	ation during most of working	unk 16b	. Kind of Business/In	dustry unk
2	212	d with giene. r than	mo.	Elementary/Secondary (0-12) Columb unk	lege (1-4or 5+)		,			
who	pu	ild be fifed lental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last)		unk	18. Mother's Name	(First, Middle, Maid	en Sumame)	unk
ranles Herrin	Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28e-f show any Injury or other treumatic event, the Madical Exercine membrates in Milled at once.		19a. Informant's Name/Relationship (Type, Pri. Joseph Richey Hos		iling Address <i>(Street a</i> 8 Eutaw St	and Number or Rural reet Balt	Route Number, Cit	y or Town, State, Zip 21201	Code)
2	Jre,	of Hear item		20a. Method of Disposition	20b. Place of Dis	position (Name of ematory or other place	Da	ate 20c.	Location - City or To	own, State
3	Ē	Page ment ant: If ury o		1 □ Burial 2 □ Cremation 3 □ Remova 4 □ Donation 5 ☑ Other (Specify) in		,				
Cha	Baltimore,	Departiment Import any Injury Conce.		21. Signature of Juneral Service Licensee Ronald S. Wade	Director S	^{22. Name and Addres} tate Anato altimore,	s of Facility my Board	655 W. Ba	ltimore S	treet
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د	O. B	the dear y the att	Physician/Med	1 Yes 2 No		Other (specify)			Month	Day Year
AM	ds, P	S	ρ	Part II. Other significant conditions contributing	g to death but not resulting in the	underlying cause give	on in Part I.		o use contribute to the	
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	_	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical Ce	(Orack ora) Z medical Examiner: On	To the best of my knowledge, dea the basis of examination and/or it	ath occurred at the time	e, date and place, ar inion, death occurred	nd due to the cause d at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
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•				30. Name and address of person who complete	d cause of death (Item 23a) (Type	p, Print)	0.11		ly 31, 201	-10
				E. Tso MD Richey H	ospice 838 N.	Evitaw St	- Baltin	iore MD	2/20	9
	**************************************	Sta Registr		31. Date filed (Month, Day, Year) ALIG 0 4 2006	32. Registrar's Signature	Res !				

			1 - For State Registrar	State of Marylan		rtment of tificate of		Mental Hy	/giene	06 24495	
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of D		3. Time of Death	
r.	/Medic Examir		4a. Facility Name (If not institution, give of Mercy Medical	Street and number)		4b. City, Town, Balti	or Location of Deat	h	4c. County of	006 11:15AM	
	Funeral Director		5. Social Security Number 6. Sec. 554-11-7088 1 C	7. Age (In yrs. 1	ast birthday) Yrs.	If Under 1 Yea Months Days			rth ay, Year) 7, 1970	9. Birthplace (State or Foreign Country) WA	
	he Marylan 8s-f show	ector	10a. State 10b. County	A 10c. City	r, Town or Loc	LTIMOL	e			10d. Inside City Limits 1 ✓ Yes 2 ☐ No	
	3a or 2	I Dir	3518 Northe	rn PARKWA	es	10f. Zip Code	1206		10g. Citizen of Wh		
936	iges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Items 23s or 28s-f show or other traumatic evant, the Madical Expendial Traust be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	S. 13. W	as Decedent of Yes, specify Cu	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or Noto Rican, etc.)	14. Race Black, Specify:	American Indian, White, etc.	
Maryland 21215-0036	within 72 horiene.	Be Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	College (1-Aor 5+) (Give kind of work done during most life. DO NOT use retired)			rking	16b. Kind of Busi	1 Business/Industry	
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	1 and 2 sh Health and em 27 is m ther traum	1	La. Informant's Name/Relationship (Ty Log VAA CLIS 20a. Method of Disposition		19b. Mailing 35(8) lace of Disposi	Nost		Luny Bate Date	er, City or Town, St	21206	
Baltimore,	rtmer rtent rtent		t Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	lemoval from State	lens of	atory or other pl	8 2	66	Rosedale		
Ba	Depa Impo any i		Maul:M.	Stella	PA	Ul STZI	or Ro. T	al Home	21834		
	Physician /Medical		23a. Pani. Enter the disease, or complishock, or heart failure. List only or Immèdiete Cause (Final disease or condition resulting in death)	Metastat	ic ove				irrest,	Approximate Interval Between Onset and Death	
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sion o	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2:		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju			how injury occurred	(4)	
Division	Hospital or Atti 24 hours after de Funeral Directi tely filled in by t	Certification;	3 Suicide 6 Could not be determined						Location (Street and Number or Rural Route Number, City or Town, State)		
	the Hosp hin 24 hou the Fune npletely fil	edical	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Examination	sician: To the best of my knowner: On the basis of examinat and manner stated.	wiedge, death o ion and/or inve	occurred at the testigation, in my	ime, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)	
	To the To the Comp	ž	29b. Signature and title of certifier	210 11	7	_	se number		29d. Date signed (
1	7		30. Name and address of person who co		23a) (Type, Pr	rint)	04666	·		8,2006	
	Sta	te	301 ST, PAUI 31. Date filed (Month, Day, Year)	P(CLCC) 32. Registrar's Signat		more	e, MD	2120	02		
	Registr		AUG 0-4-20			ast.					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 4a, c. 23 pt. 11 per doc 858 8-4-06 vt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month AUGUST 3:35 PM 2006 Lee Roy Husk
4a. Facility Name (Samarinot and street and number) 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAL HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 12 M 2□ F Yrs. 82 233-32-7317 West Virginia Feb. 1924 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1102 East Viking Court

12. Was Decedent Ever in U.S. Armed Forces? 21009 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3 Maintenance State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William H. Husk Lydia (unk) (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret M. Husk / Wife 1102 East Viking Court, Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 8-3-06 Towson, Maryland McConas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part. Enter the disease, or complications that caused the dean. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? PNEUMONIA 1 ☐ Yes 2 ☐ No 20 No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Box 68760 Division of Vital Records, within 24 hours after death. To the Funerel Diractor: After this certific completely filled in by the funeral director, filled in by the

Physician

/Medical

Examiner

Funeral

Director

28e-f show

Items 23a

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7 Is marked other than "

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic events injury or other traumatic events.

Physician

Directo

Completed by Funera

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other traumatic event, the Madical Examiner must be notified at

Baltimore, Maryland 21215-0036

disease or condition resulting in death) Sequentially list conditions, I any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Physician/Medical IF FEMALE. 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical Be 1 Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Gneck only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) AUG 0 4 2006 32. Registrar's Signature

30. Name an addres, of person who completed cause of death (Item 23a) (Type, Print)

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RAVEN BLUD BALTIMORE MD-2129

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician AUGUST** 2006 BEATRICE HAMBURGER 2:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4700 ATRIUM COURT OWINGS MILLS BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2∏F 89 Yrs. 108-07-6257 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Directo MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Insportant: If Item 27 is marked other than "natural", or Iteme 23a any injury or other traumatic event, the Medical Examination ODEs. 4730 ATRIUM COURT APT. #179 21117 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No δ Specify 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SPER0 DEBBY COHEN ABRAHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 E. LEE STREET #1701 - BALTIMORE, MD 21202 DAVID HAMBURGER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HILLTOP SERVICE CORP. 08/04/2006 TOWSON, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inifiated events resulting in death) Last Due to (or as consequence of) Examine g physicien and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, ourcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes 2. No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this ieral Director: After th 28b. Time of 28a. Dafe of Injury (Month, Day Year) Certification: 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 Date filed (Month, Day, Year) 32. Fegistrar's Signature State AUG 0 4 2006 Registrar

Davon Shashazz Hines

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certificate of	of Death		Reg	. No. 201	15 2.1.9	
Physicia Medical Examir		Decedent's Name (First, Middle, La DAVON		2. Date of Death Month August 1, 2	Day Year	3. Time of Death 0555 hrs				
		4a. Facility Name (if not institution, g Johns Hopkins Hospital	ve street and number)		4b. City, Town, o Baltimore	or Location of Death		4c. County of Death N/A		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. B Fore Months Days Hours Min. JULY 13.1987								
âu k		Usual Residence of Decedent 10a State 10b. County	100	c. City, Town or Loc	ation				10d. Inside City Limits	
5	ō	MD. N/	A	BALTI	MORE				1X Yes 2 No	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	10e. Street and Number 2327 E. MADI	SON ST.		10f. Zip Code	21205	100	DSA	intry?	
hours after death with the Mary land natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce	12. Was Decedent Eve Armed Forces? 1 Yes 2X	lf		lispanic Origin? (San, Mexican, Puerto		White, etc.	ican Indian, Black,	
ours aft.	d by	15. Decedent's Education (Specify	or Dates:		ent's Usual Occup	ation (Give kind of fe. DO NOT use ret			b. Kind of Business/Industry	
36 In 72 lical	Completed	Elementary/Secondary (0-12) 10TH	College (1-4 or 5+)		ORER	e. DO NOT use let	ired)	BURGER F	KING	
		17. Father's Name (First, Middle, Las					e (First, Middle, Ma			
2121 mild be fill marked c event.	o Be	DONNEILL TAT 19a. Informant's Name/Relationship (19b. Maili	ng Address (Stre	KENYA		er, City or Town, State	e, Zip Code)	
		JAMES & KENYA 20a Method of Disposition	DULI 1 DC .	nother)	2327 E.	MADISO	N ST. I	BALTO, MD.	21205	
im Pag nent lant: or of			Removal from State	20b. Place of Disport crematory or of TRINITY	other place) CEM.	AUG	.9,200	20c. Location - City or BALTO, N	MD.	
Baltimo poinit Pag Department Important: injiny or of		21 Supparture of Funeral Service Lice	ensee					ERAL HOME		
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/Medical ×aminer		Immediate Cause (Final disease or condition resulting in death)	Multiple Gunshot V						Death	
	_	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ance of):						
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated								
		events resulting in death) Last		erice or).						
760, cate be execute physician and the burial - tran	/Medical	UNPENDED	AMENDED							
\$8760, artificate be ling physici as the buri		IF FEMALE: 23b Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 🔲 F	Fetal death 3	Ectopic pregna	ancy	23d. Date of deliver Month	y Day Year	
Box 68' c death certifi the attending ed for use as	Physicial	1 Yes 2 No 9 Unknow	4 Pregnant at time 9 Unknown	e of death 5	Other (Specify)					
, P.O. B ros that the d signed by the be detached	by Ph	Part II. Other significant conditions	contributing to death bu	ut not resulting in the	underlying cause	given in Part I.		acco use contribute to		
ds, F	eted						24a. Was ar	24b. Were au	utopsy findings available	
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ian: T	Be C	25. Was case referred to medical examiner?	Hoonstol			ce of Death (Check	only one)			
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To the Hos within 24 h To the Fu	Medical	one) 2 Medical Examina 29b. Signature and title of certifier	er: On the basis of examination and manner stated.	ation and/or investig		nse number		and place, and due to tr		
		Potulism.	O.C.M.E.					August 2, 2006	,	
3		30. Name and address of person who Patricia Aronica-Pollak M		h (Item 23a) dical Examiner	111 Penn S	Street, Baltimor	re, MD 21201			
St. Regist	ate rar	31. Date filed (Month, Day, Year)	006 32. Registrar's	Signature	will					
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	g *		Decedent's Name (First, Middle, Last)		2. Date of Death					3. Tim		
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	Examin								4c. Co	4c. County of Death		
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	or 28	Director	10e. Street and Number	10f	. Zip Code				10g. Citizen	of What Co	untry?	
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П			23a. Part1. Ententhe disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the	mode of dying	, such as c	cardiac or r	respiratory arr	est,		Approximate Interval Between	
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	/Medical Examiner		resulting in death) Due to (or at a consequence of	f):	rdw	lace		in d	de ani	-0		
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	spital ours a naral filled		29a. Certifier (Scertifying Physician: To the best of my knowledge,	death occur	rred at the time	e. date and	d place, and	d due to the c	ause(s) and	manner as	stated	
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L	To the Hospital of within 24 hours affice to the Funeral Discompletely filled in	Me	29b. Signature and title of certifier		29c. License	-	0/	2	9d. Date si	gned (Month	Day, Year)	
	0		Victoria Value MD		D3	23	81	1	tugu.	15 +2	2006	
9)		30. Name and address of person who completed cause of death (Item 23a) (1906 Philadliping Rd # 3	Type, Print)	Balt	moi	R	MD .	212	37		
• • •	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 4 2006 32 legistrar's Signature	Spark	e e							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Dav HARRY MASANDO IWATA August 1, 2006 2:55 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 7602 Far Hills Drive Towson Baltimore If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct. 18, 1 Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 85 Director 140-24-6721 1920 Washington Usual Residence of Decedent with the Maryland 10a. State 10b. County Department of Health and Mental Hygiene. Important: or Iteme 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at any injury or other traumatic event, the Medical Examinat must be notified at angles. 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland | Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7602 Far Hills Drive 21286 Funerai death U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atternent of Health and Menial Hygiene. Int: If Item 27 Is marked other than "natural", or Ite 1 ☐ Never Married 2 ☐ Married 1 XYes 2 No If Yes, Give Year or Dates:1945-46 Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specity: Specify: 3 ☐ Widowed 4 ☐ Divorced Japanese Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Efementary/Secondary (0-12) College (1-4or 5+) Chemical Engineer 5+ years Chemical 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Masuko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Y. Iwata (wife) 7602 Far Hills Drive Towson, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens 8-7-06 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell - Wiedefeld Funeral Home, Inc. Sleave Ferral 6500 York Road Baltimore,

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myocardial Interction /Medical Due to (or as a consequence of): Examiner petensii. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or is a consequence of) ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ zheimer's Demention 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed: 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0059388 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Darid Welsman Loch Rower Baltimore 31. Date filed (Month, Day, Year) 3 Registrar's Signature State AUG 0 4 2006 Registrar